

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05997

CERTIFICATE OF DEATH

05986

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LONA CONING		c. LENGTH OF STAY IN 1b 3 WEEKS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) KYLE NURSING HOME				d. STREET ADDRESS 112 WEBER STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last JESSE ERNEST ABERNATHY				4. DATE OF DEATH Month Day Year MAY 17 19 67			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOV. 7, 1902		9. AGE (In years last birthday) 64 yrs.	10. IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MECHANIC		10b. KIND OF BUSINESS OR INDUSTRY GARAGE		11. BIRTHPLACE (County & State, or foreign country) CROSS, W. VA.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JESSE G. ABERNATHY				14. MOTHER'S MAIDEN NAME SARAH RANDALLS			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 214 05 6255		17. INFORMANT Address MRS. ZELDA ABERNATHY, CUMBERLAND, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial ischemia DUE TO (b) generalized arteriosclerosis DUE TO (c) azotemia with uremia						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION, GIVEN IN PART I (g) Previous Gastrointestinal hemorrhage; generalized arthritis						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Nov 20, 1966 to 5/18/1967 , that (I) (we) last saw the deceased alive on 5/18/1967 , and that death occurred at 630 P.M. from causes and on the date stated above.							
22a. SIGNATURE Richard E. Schindler				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED MAY 18, 1967	
22c. PHYSICIAN'S NAME (Type) RICHARD E. SCHINDLER, M.D.				22d. ADDRESS 69 GREENE ST. CUMBERLAND, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF MAY 20, 1967		23c. NAME OF CEMETERY OR CREMATORY COOK'S MILL CEMETERY		23d. LOCATION (City or Town) (County) (State) HYNDMAN BEDFORD PA.	
24. FUNERAL DIRECTOR BYRON KIGHT				CUMBERLAND, MD.		25a. REC'D BY REGISTRAR DATE MAY 22 1967	
				25b. REGISTRAR'S SIGNATURE J. Charles Judge			

33018



33018

THE LIBRARY OF THE
U.S. DEPARTMENT OF THE INTERIOR
BUREAU OF LAND MANAGEMENT
1015 N. 1st St., Denver, CO 80202
303-837-1999

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
20M 1/65

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>											
1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN 1b 12 DAYS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SACRED HEART HOSPITAL						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) LA VALE d. STREET ADDRESS 1233 NATIONAL HIGHWAY e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) JOSEPHINE First 5. SEX FEMALE 6. COLOR OR RACE WHITE 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 03-06-23 9. AGE (In years last birthday) 44 yrs. IF UNDER 1 YEAR Months 19 Days 19 Hours 67 Min.				4. DATE OF DEATH MAY 19 19 67 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) SANDYHOOK, MARYLAND 12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME WILLIAM COLE 14. MOTHER'S MATEEN NAME MARY (COOPER) COLE				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO 16. SOCIAL SECURITY NO. 219-12-2114 17. INFORMANT HOSPITAL RECORDS							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Dehydration; Pulmonary Atelectasis</i> 170X DOE TO <i>Right - Pleural Effusion</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DOE TO <i>Carcinoma, for advanced right breast & metastasis</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Marked Jaundice & Hepatic Metastasis</i>										INTERVAL BETWEEN ONSET AND DEATH <i>2 weeks</i> <i>2 mos.</i> <i>1 yr.</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <i>MAY 7 - 1967</i> to <i>MAY 19 - 1967</i> that (I) (we) last saw the deceased alive on <i>5-19-1967</i> and that death occurred at <i>1 PM</i> from the causes and on the date stated above.											
22a. SIGNATURE <i>Richard Schindler</i> M.D. ATTENDING PHYS. <input type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <i>5/22/67</i>						22c. PHYSICIAN'S NAME (Type) RICHARD E. SCHINDLER 22d. ADDRESS 69 GREENE ST., CUMB., MD., 21502					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF <i>5/22/67</i>		23c. NAME OF CEMETERY OR CREMATORY <i>St. Mary's Catholic Cemetery</i>		23d. LOCATION (City, town or county) (State) <i>Near Cumberland, Md</i>					
24. FUNERAL DIRECTOR <i>John J. Hafer, Jr.</i> ADDRESS <i>230 Balto Ave., Cumberland</i> DATE <i>MAY 21 1967</i>						25a. MADE BY REGISTRAR <i>James Judge</i> 25b. REGISTRAR'S SIGNATURE					

MD

05083

ALFRED

WILLIAM

ALFRED

LA WIFE

12 DAYS

CHAMBERLAND

1333 NATIONAL HIGHWAY

SACRED HEART HOSPITAL

2

10

MAY

ALBERT

C.

JOSEPHINE

XX

40

07-08-23

WHITE

FEMALE

U.S.A.

SANDYHOCK, WISCONSIN

HOMESIDE

MAY (COOPER) COLE

WILLIAM COLE

HOSPITAL RECORDS

210-12-2114

NO

60 GREEN ST., CHICAGO, ILL. 60607

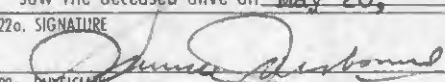
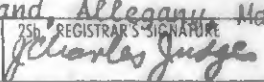
RICHARD E. SCHWOLTER

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05999

CERTIFICATE OF DEATH

05988

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 2 DAYS 18HRS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		e. STREET ADDRESS HILL CREST DRIVE	
3. NAME OF DECEASED (Type or print) First Middle Last DOROTHY S. AMICK		4. DATE OF DEATH Month Day Year MAY 21 1967	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-28-1896
9. AGE (In years last birthday) 71 yrs.		10. USUAL OCCUPATION (Give kind of work done during part of working life, even if retired) Corporate Officer	
11. BIRTHPLACE (County & State, or foreign country) MARYLAND, Hagerstown		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME STREET, JOHN MR.		14. MOTHER'S MAIDEN NAME SPICER, JESSIE MRS.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 235-30-2163	
17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma of liver DUE TO 1 yr. Plus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Adenocarcinoma right hemicolon DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Uremia		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Feb. 14, 1966 , to May 21, 1967 , that (I) (we) last saw the deceased alive on May 20, 1967 , and that death occurred at 12:15 A.M. causes and on the date stated above.			
22a. SIGNATURE 		22b. DATE SIGNED May 22, 1967	
22c. PHYSICIAN'S NAME (Type) DR. JACOBSON		22d. ADDRESS 50 PERSHING ST, CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5/23/67	23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany, Md.
24. FUNERAL DIRECTOR H. Wayne George		25a. REC'D BY REGISTRAR MAY 24 1967	
Address Cumberland, Md.		25b. REGISTRAR'S SIGNATURE 	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

42020

40230

TABLE 1. *Continued*

• • •

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

06000

CERTIFICATE OF DEATH

05989

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MINERS HOSPITAL		d. STREET ADDRESS 70 WALNUT ST.	
3. NAME OF DECEASED (Type or print) ANTHONY FRANCIS ARNONE		4. DATE OF DEATH Month MAY Day 11 Year 19 67	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT. 21, 1905
9. AGE (In years last birthday) 61 yrs.		10. IF UNDER 1 YEAR Months 10 Days 10 Hours 10 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MAINTENANCE MAN		10b. KIND OF BUSINESS OR INDUSTRY HOTEL	
11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME LOUIS ARNONE		14. MOTHER'S MAIDEN NAME CATHERINE QUALTIRE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW 2		16. SOCIAL SECURITY NO. 215-05-8055	
17. INFORMANT MRS. JENNIE ARNONE, FROSTBURG, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO (b) Cardiovascular disease DUE TO (c) 2 yrs -		INTERVAL BETWEEN ONSET AND DEATH 2 yrs -	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Dec 1966 , to May 11, 1967 , that (I) (we) last saw the deceased alive on May 10 1967 , and that death occurred at MD , from causes and on the date stated above.			
22a. SIGNATURE John B. Davis, M.D.		22b. DATE SIGNED 5/12/67	
22c. PHYSICIAN'S NAME (Type) JOHN B. DAVIS, M. D.		22d. ADDRESS 2 BROADWAY, FROSTBURG, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF MAY 13, 1967	23c. NAME OF CEMETERY OR CREMATORY ST. MICHAEL'S CEMETERY	23d. LOCATION (City or Town) (County) (State) FROSTBURG, MD.
24. FUNERAL DIRECTOR JOSEPH R. DURST, SR., FROSTBURG, MD.		25a. REC'D BY REGISTRAR MAY 15 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

02922

00000



CERTIFICATE OF DEATH

Reg. Dist. No. 05990

06001

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>McCoole</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>McCoole</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Home 16 Queen Street</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Sarah Ann Beavers</u>				4. DATE OF DEATH <u>May 1, 1967</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 5, 1880</u>	
9. AGE (In years lost birthday) <u>87</u> yrs.		10. IF UNDER 1 YEAR <u>x</u> Months <u>26</u> Days		11. IF UNDER 24 HRS. <u>26</u> Hours <u>1</u> Min.		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired House Wife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>			
11. BIRTHPLACE (State or foreign country) <u>Herndon, Va.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Richard Reeves</u>				14. MOTHER'S MAIDEN NAME <u>Nancy Frye</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>217-48-2512</u>			
17. INFORMANT <u>Elwood Beavers, McCoole, Md.</u>				Address <u>McCoole, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CVA (Son)</u> 331X DUE TO <u>atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>many years</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Interval between onset and death</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from _____, 19____, to <u>5-1</u> , 19 <u>67</u> that I last saw the deceased alive on <u>5-1-67</u> , 19____, and that death occurred at <u>8:45</u> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____							
ACTUAL SIGNATURE <u>William W. Lesh</u>				M.D. <u>Westernport, Md.</u> <u>5-3-67</u>			
PHYSICIAN'S NAME (Type) <u>William W. Lesh</u>				<u>Westernport, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-3-67</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Philos Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Westernport, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Thomas W. Keyser Jr.</u>				24a. REC'D BY REGISTRAR <u>MAY 5 1967</u> 24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			
ADDRESS <u>Keyser, W. Va.</u>							

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

SECRET

12-10-50

12-10-50

12-10-50

12-10-50

12-10-50

12-10-50

12-10-50

12-10-50

12-10-50

12-10-50

12-10-50

12-10-50

12-10-50

12-10-50

12-10-50

12-10-50

12-10-50

12-10-50

12-10-50

12-10-50

12-10-50

12-10-50

12-10-50

12-10-50

12-10-50

12-10-50

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove ~~pages 1 and 2~~ and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

06002

CERTIFICATE OF DEATH

05991

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Gilmore) R-F-D-Frostburg, Md.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Miners Hospital				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MARTHA E BEEMAN				4. DATE OF DEATH Month 5 Day 11 Year 1967			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/21/1897	9. AGE (In years last birthday) 69 yrs	10. IF UNDER 1 YEAR Months Days Hours Min		11. IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Lonaconing, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Leo McKenzie				14. MOTHER'S MAIDEN NAME Eleanor Coleman			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Charles Beeman Address Gilmore, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary occlusion - (Husband) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) HCVD C arteriosclerosis DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 4 hrs - 3 yrs -			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 6, 1967 to 3/11, 1967 that (I) last saw the deceased alive on 5/11, 1967 , and that death occurred on 5/11, 1967 , from causes on and on the date stated above.							
22a. SIGNATURE John B. Davis				22b. DATE SIGNED 5/11/67		22c. PHYSICIAN'S NAME (Type) John B. Davis, M.D.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 5/15/1967		23c. NAME OF CEMETERY OR CREMATORY St Josephs Cemetery	
23d. LOCATION (City or town) Midland, Md.				23e. BY REGISTRAR May 15 1967		23f. REGISTRAR'S SIGNATURE George Eichhorn	
24. FUNERAL DIRECTOR George Eichhorn				24b. ADDRESS Lonaconing, Md.			



06003

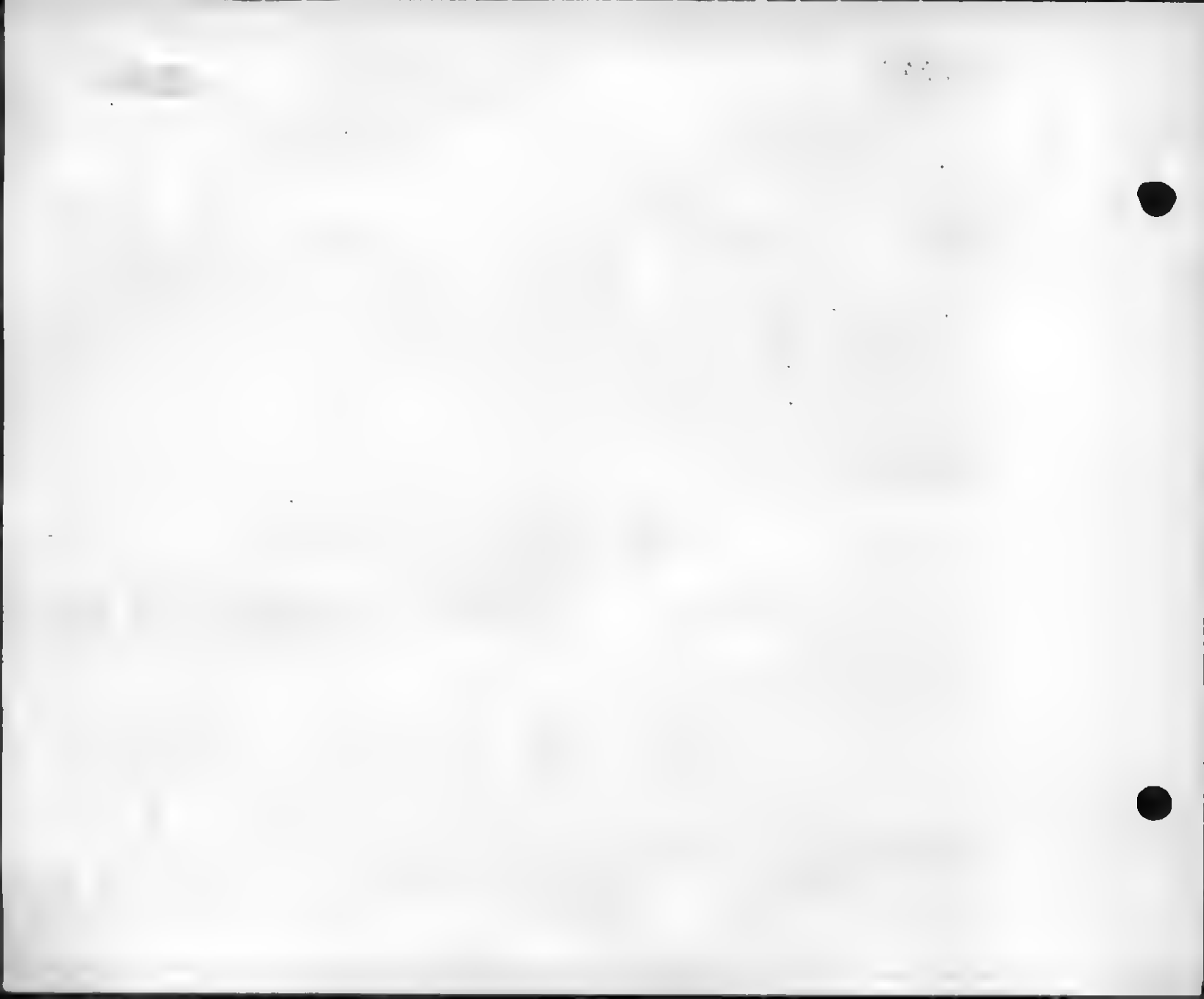
CERTIFICATE OF DEATH

05004

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>		c. LENGTH OF STAY IN lb	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Miner's Hospital</u>		d. STREET ADDRESS <u>New Row</u>	
3. NAME OF DECEASED (Type or print) <u>John H. Brailer</u>		4. DATE OF DEATH <u>May 24 1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 31 83</u>
9. AGE (in years last birthday) <u>83</u> yrs		10. IF UNDER 1 YEAR: Months <u>1</u> Days <u>24</u> Hours <u>19</u> Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>W. Savage Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>George C Brailer</u>		14. MOTHER'S MAIDEN NAME <u>Emma Durbin</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <u>Mr. Clinton Brailer</u>		Address <u>W. Savage</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Terminal Uremia - due to Chronic renal failure</u>			
(b) <u>Arteriosclerotic Hypertensive CVD.</u>			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NONE</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <input checked="" type="checkbox"/>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>5/16</u> , 1967, to <u>5/24</u> , 1967, that (I) (we) last saw the deceased alive on <u>5/24</u> , 1967, and that death occurred at <u>2:30 A.M.</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Martin M. Rothstein</u>		22b. DATE SIGNED <u>5/25/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>MARTIN M. ROTHSTEIN M.D.</u>		22d. ADDRESS <u>48 BROADWAY - FROSTBURG MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>5/27/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Patricks Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>W. Savage Md</u>
24. FUNERAL DIRECTOR <u>Lewis Stein Inc.</u>		25a. REC'D BY REG. STRAR <u>Charles Jones</u>	
25b. DATE <u>MAY 29 1967</u>		25c. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



1
FOR STATE
HEALTH-DEPT.

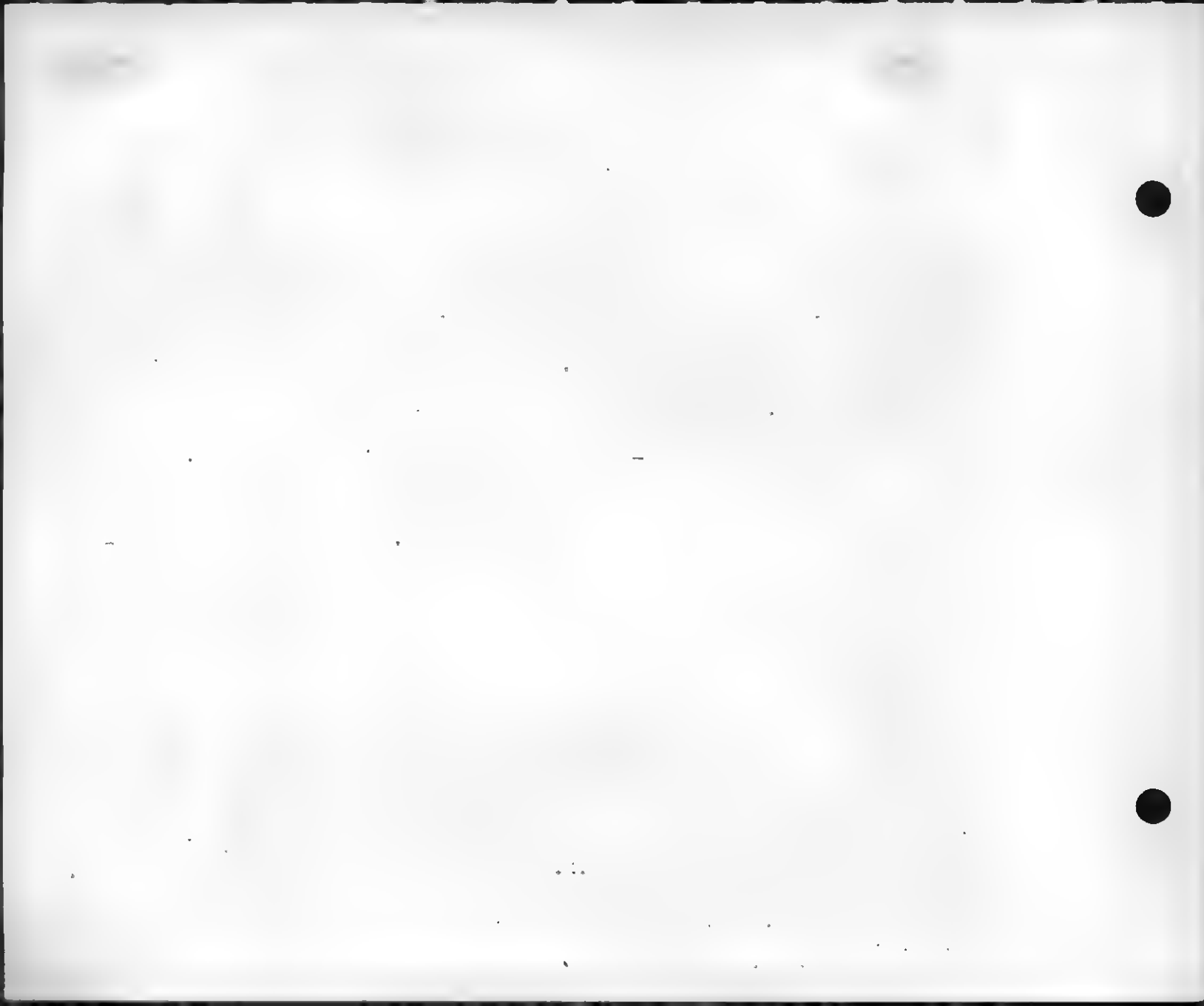
TO DEPUTY MEDICAL EXAMINER: This certificate is to be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

06004

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Allegany County		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN b. 83 Years	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 939 Glenwood Street		d. STREET ADDRESS 939 Glenwood Street	
3. NAME OF DECEASED (Type or print) First Noah Middle Alfred Last Brown		4. DATE OF DEATH Month May Day 5 Year 1967	
5. SEX Male	6. COLOR OR RACE Black	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 15, 1883
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired City Employee		10b. KIND OF BUSINESS OR INDUSTRY Street Dept.	9. AGE (in years last birthday) 83 yrs.
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Albert J. Brown		14. MOTHER'S MAIDEN NAME Agnes Cooke	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218-38-2360	
17. INFORMANT Cumberland City Police Dept.		Address Cumberland Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO (b) Coronary Sclerosis DUE TO (c) ---			INTERVAL BETWEEN ONSET AND DEATH Sudden
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Benedict Skitarellic</i>		22. DATE SIGNED May 5, 1967	
EXAMINER'S NAME (Type) Benedict Skitarellic, M.D.		Address (Street, city, town, or county) Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF May 10, 1967	23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery	23d. LOCATION (City, town or county) (State) Near Cumberland, Maryland
24. FUNERAL DIRECTOR John J. Hafer, Jr.		25a. REC'D BY REGISTRAR 9 1967	
Address 230 Balto Ave. Cumberland Md		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

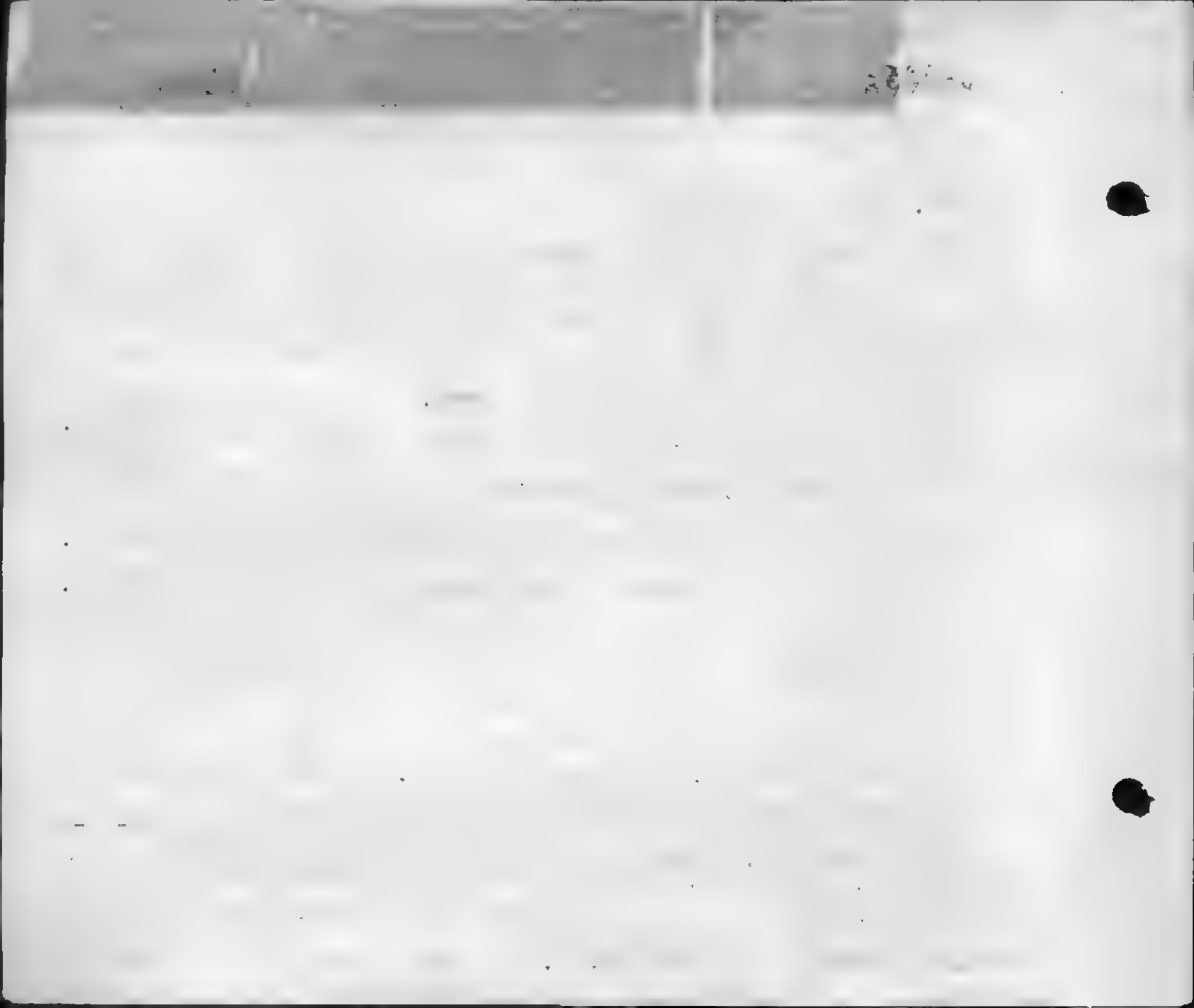


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

06005
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) LaVale c. LENGTH OF STAY IN 1b 68 years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 908 Nat. Highway, LaVale, Maryland		2. USUAL RESIDENCE (Where deceased lived, if not usual residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) LaVale, Maryland d. STREET ADDRESS 908 NATIONAL HIGHWAY e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) LESTER WILSON BROWNING First Middle Last		4. DATE OF DEATH MAY 12 19 67 Month Day Year	
5 SEX MALE 6. COLOR OR RACE WHITE 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MAY, 25, 1898 9. AGE (In years, first birthday) 68 If UNDER 1 YEAR: Months Days If UNDER 24 HRS.: Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER 10b. KIND OF BUSINESS OR INDUSTRY CARPENTER		11. BIRTHPLACE (County & State, or foreign country) CUMBERLAND, MARYLAND 12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME RUSSELL BROWNING		14. MOTHER'S MAIDEN NAME MRS. JULIA F. (JACKSON) BROWNING Address LaVale, Md.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) YES WWI		16. SOCIAL SECURITY NO. 214-05-6395	
17. INFORMANT MRS RUTH V. BROWNING Address 908 NATIONAL HIGHWAY		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (b) Hypertensive Heart Disease (c), stating the underlying cause last. Coronary artery disease DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None INTERVAL BETWEEN ONSET AND DEATH 1 day 25 yrs. 25 yrs.	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) None		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) None		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 8, 19 66 to May 12, 19 67 that (I) (we) last saw the deceased alive on May 12, 19 67 and that death occurred at 5.25 PM the causes and on the date stated above.			
22a. SIGNATURE James P. Hallinan MD		22b. DATE SIGNED 5-12-67	
22c. PHYSICIAN'S NAME (Type) DR. JAMES P. HALLINAN		22d. ADDRESS 1140 BEDFORD STREET, CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 15 MAY 67	
23c. NAME OF CEMETERY OR CREMATORY REST LAWN MEMORIAL PARK		23d. LOCATION (City, town or county) (State) LaVale, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Boyle L. Merritt ADDRESS 404 Decatur street CUMBERLAND, MD.		25a. REC'D BY REGISTRAR MAY 16 1967 25b. REGISTRAR'S SIGNATURE J. Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

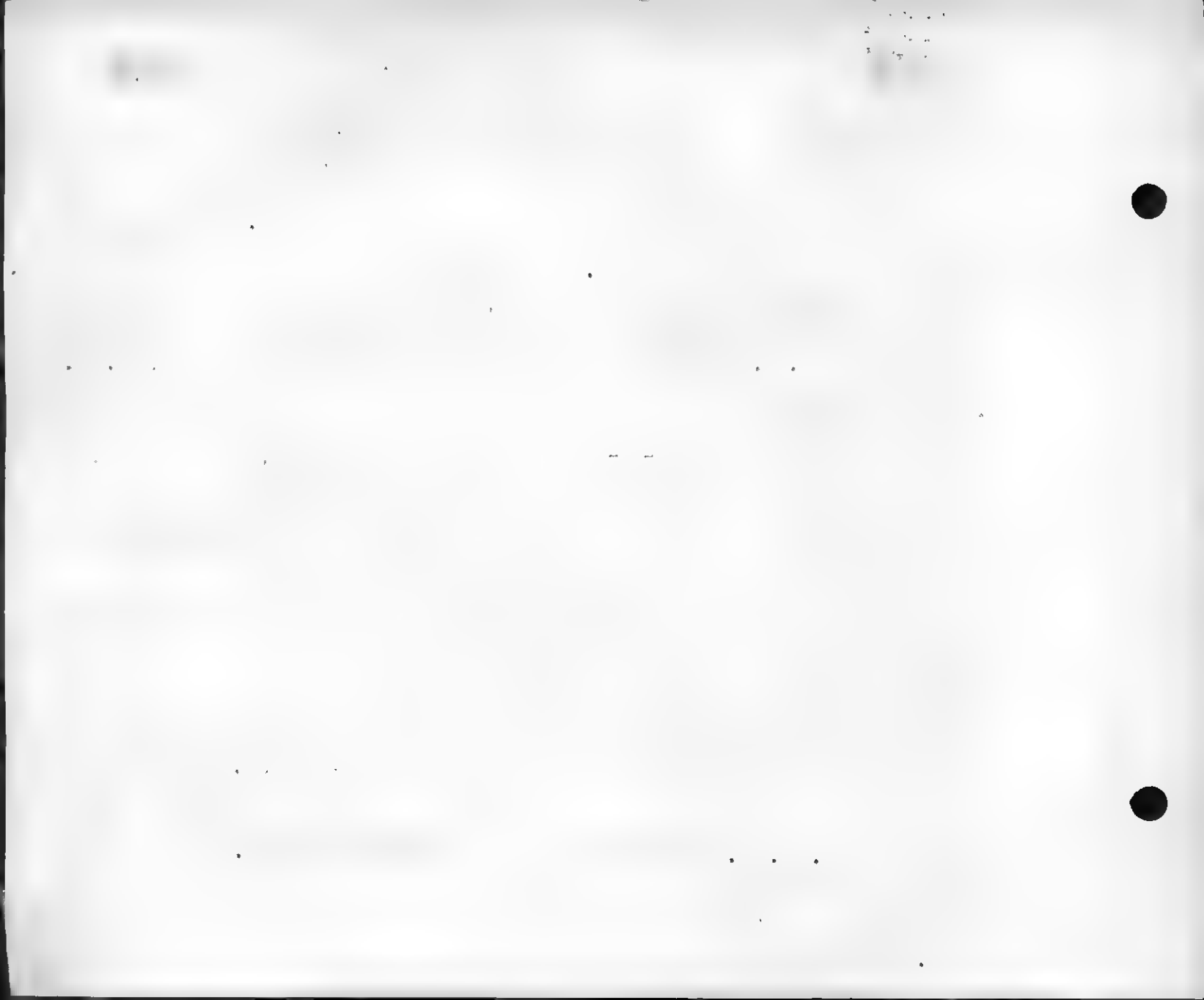
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06806

CERTIFICATE OF DEATH

15986

1 PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY in 1b 19 DAYS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND d. STREET ADDRESS 410 DECATUR ST. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First JOSEPH Middle F. Last BUCKLEW		4 DATE OF DEATH Month MAY Day 10 Year 1967	
5 SEX MALE	6 COLOR OR RACE WHITE	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 1-15-1876
10a USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) Retired B & O R. R. Conductor		10b KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (County & State, or foreign country) WEST VIRGINIA
13 FATHER'S NAME BALDWIN BUCKLEW		14 MOTHER'S MAIDEN NAME Rachael Rhodes	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO 705-09-7801	17 INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cordiac arrest, terminal Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic heart disease with DUE TO (c) longstanding far advanced arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH present
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 2:30 pm , 19 67 , that (I) (we) last saw the deceased alive on 10 may , 19 67 , and that death occurred at 5:10 P.M. , from causes and on the date stated above			
22a SIGNATURE W. Alfred Van Ormer		22b. DATE SIGNED 6 May 67	
22c. PHYSICIAN'S NAME (Type) DR. W. A. VAN ORMER		22d ADDRESS CUMBERLAND, MD.	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5/13/67	23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park	23d LOCATION (City or Town) (County) (State) Cumberland Allegany Maryland
24. FUNERAL DIRECTOR H. Lee Silcox		25a REC'D BY REGISTRAR MAY 15 1967	
Cumberland Maryland 21502		25b REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06007

CERTIFICATE OF DEATH

05997

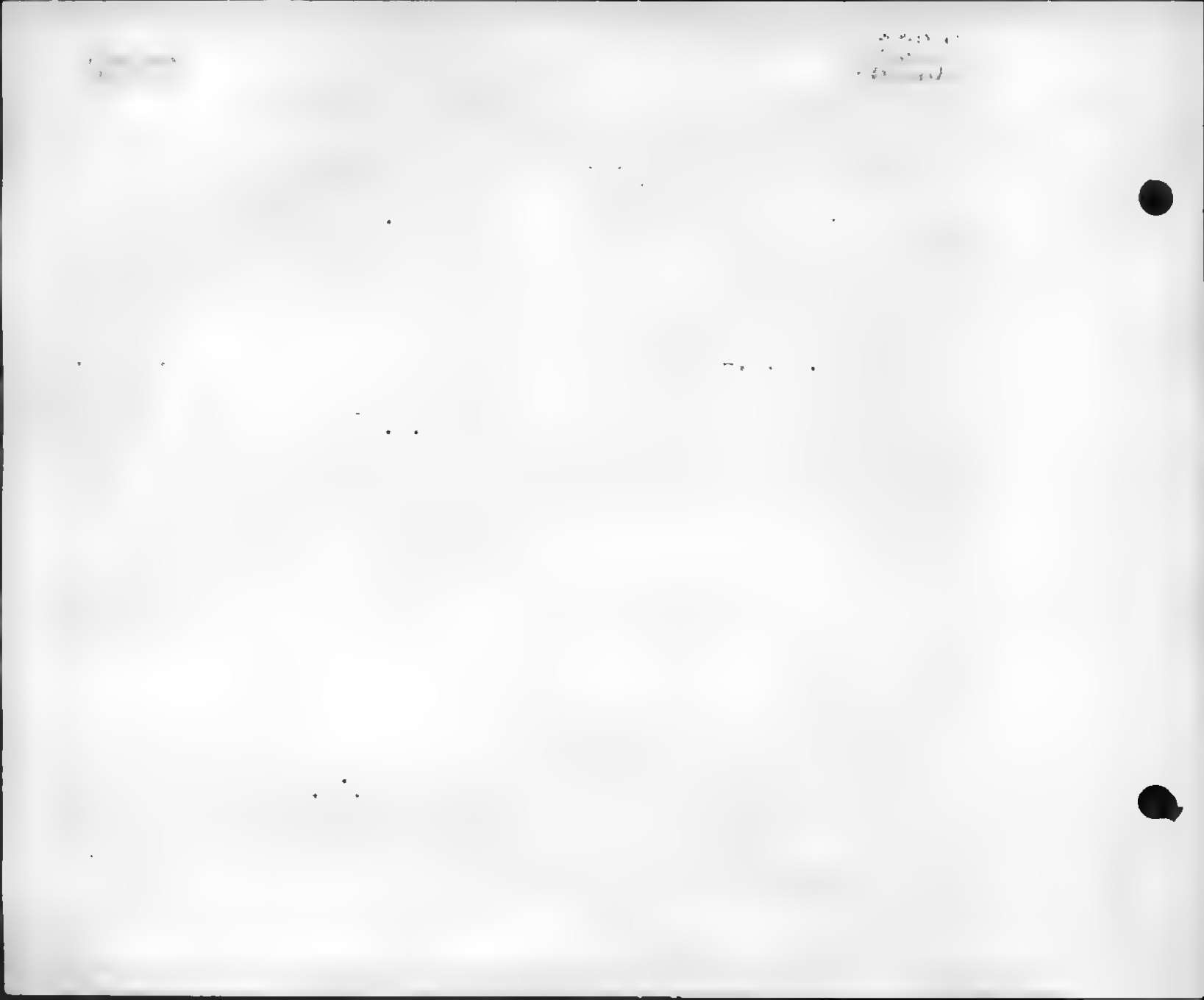
1. PLACE OF DEATH a COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE MARYLAND b COUNTY ALLEGANY	
b CITY OR TOWN (If outside corporate limits, write RJRAL and on) CUMBERLAND		c LENGTH OF STAY IN 1b 1 MO.	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		d. STREET ADDRESS 212 CECILIA STREET	
3. NAME OF DECEASED (Type or print) First JAMES Middle R Last CAMPBELL		4. DATE OF DEATH MAY 18, 1967 19 67	
5 SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 1-9-1909
9 AGE (In years last birthday) 58 yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b KIND OF BUSINESS OR INDUSTRY NONE	
11 BIRTHPLACE (County & State, or foreign country) NORTH CAROLINA		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME PHILLIP CAMPBELL		14 MOTHER'S MAIDEN NAME SIPPIE MOBLEY	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Leptostic Pneumonia 2/10/4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Myocarditis DUE TO (c) Atherosclerosis		INTERVAL BETWEEN ONSET AND DEATH 3 mon 6 mon 3 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from May 15, 1967 to May 18, 1967 , that (I) (we) last saw the deceased alive on May 17, 1967 and that death occurred at 5:30 A.M. from causes and on the date stated above.			
22a SIGNATURE Clay E. Durrett M.D.		22b DATE SIGNED May 18, 1967	
22c PHYSICIAN'S NAME (Type) CLAY E. DURRETT, MD.		22d ADDRESS 236 VIRGINIA AVE., CUMBERLAND, MD.	
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
BURIAL	MAY 20, 1967	SUNSET MEMORIAL PARK	CUMBERLAND, MD.
24 FUNERAL DIRECTOR BYRON KIGHT		25a MAY 22 1967 25b REGISTRAR'S SIGNATURE Charles Judge	
ADDRESS CUMBERLAND, MD.		DATE	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
06008-				CERTIFICATE OF DEATH			05298		
1. PLACE OF DEATH a. COUNTY Allegany MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland			c. LENGTH OF STAY IN 1b 4/1/1966		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospita, give street address) Allegany County Infirmary					d. STREET ADDRESS Rt. #4, Box 9			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last George Thomas Carder					4. DATE OF DEATH Month Day Year May 29, 19 67				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/20/1874		9. AGE (n years last birthday) yrs 92	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired: W/Md. R.R.-Yard man			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME James Carder					14. MOTHER'S MAIDEN NAME Jane Twigg				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no no			16. SOCIAL SECURITY NO 212-24-0949		17. INFORMANT P.O. Box 599, Cumberland, Md. Allegany County Infirmary records.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute myocardial insufficiency DUE TO (b) aortic aneurysm DUE TO (c) Chl. ASH D. with myocardial insuff. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									INTERVAL BETWEEN ONSET AND DEATH 3 days approx. 3 mos. 20 yrs
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4/1/66 , 19__, to 5/29/67 , 19__, that (I) (we) last saw the deceased alive on 5/29/67 , 19__, and that death occurred at 10:40 A.M. , from causes on and on the date stated above.									
22a. SIGNATURE John A. Topper					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22b. DATE SIGNED 5/31/1967	
22c. PHYSICIAN'S NAME (Type) John A. Topper					22d. ADDRESS 1110 Municipal Bldg. - Cumberland, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF May 31, 1967		23c. NAME OF CEMETERY OR CREMATORY Oldtown Cemetery			23d. LOCATION (City or Town) (County) (State) Oldtown, Md. Allegany		
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.					25a. REC'D BY REGISTRAR DATE JUN 5 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judge		



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE HEALTH DEPT.

06009

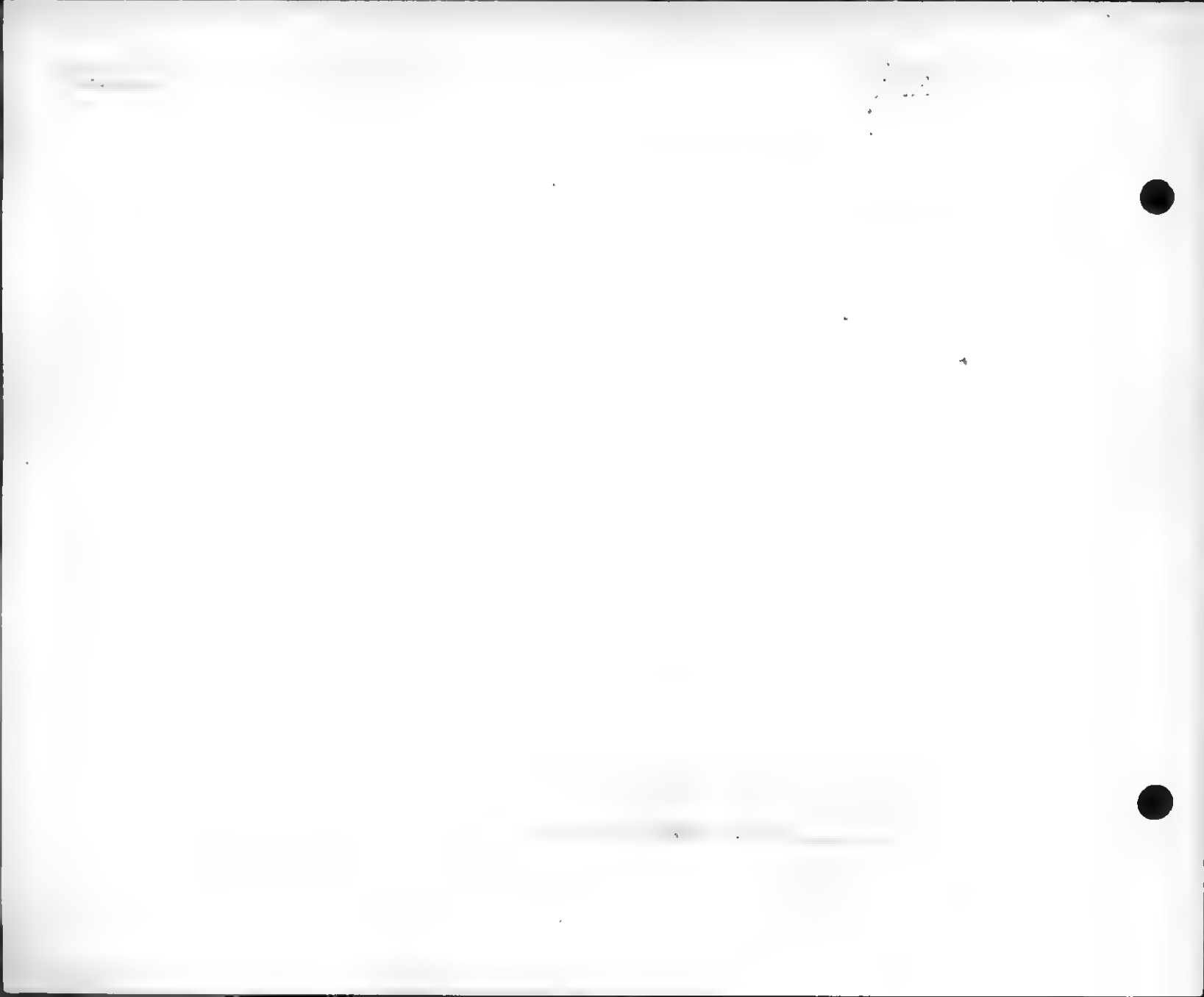
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05999

1 PLACE OF DEATH a. COUNTY Allegany MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Route 1, Oldtown Road		c. LENGTH OF STAY IN 1b 9 mos.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Bear Hill Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Soren Middle Christensen Last Christensen		4 DATE OF DEATH Month May Day 16 Year 19 67	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Sept. 5, 1889
9 AGE (n years lost birthday) 77 yrs		10 IF UNDER 1 YEAR Months 0 Days 1 Hours 1 Min 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Standard Oil Co.	
11 BIRTHPLACE (State or foreign country) Denmark		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME Unknown		14 MOTHER'S MAIDEN NAME Unknown	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16 SOCIAL SECURITY NO	
17 INFORMANT Mrs. Ann B. Bishop, Route 1, Oldtown, Md.		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Coronary Sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) (c)			INTERVAL BETWEEN ONSET AND DEATH Sudden
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)		20f. (City or town) (County) (State)	
21 I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspect on <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Benedict Skitaradic M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Dr. Benedict Skitaradic, M. D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> May 16, 1967 22 DATE SIGNED	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county) Rt. 9 Cumberland Md.	
23a. BURIAL CREMATION REMOVAL (Specify) Burial	23b. DATE THEREOF May 18, 1967	23c. NAME OF CEMETERY OR CREMATORY Davis Memorial Cemetery	23d. LOCATION (City or town) (County) (State) Cumberland, Md. Allegany
24 FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		25a. REC'D BY REGISTRAR MAY 18 1967	
25b. REGISTRAR'S SIGNATURE Dr. Benedict Skitaradic			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06870

CERTIFICATE OF DEATH

06C00

1 PLACE OF DEATH a. COUNTY Allegany MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a STATE Maryland b COUNTY Allegany	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c LENGTH OF STAY IN 1b 9/29/64	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Allegany County Infirmary		e STREET ADDRESS 11 N. Woodlawn Avenue	
3 NAME OF DECEASED (Type or print) Elizabeth R. Close		4. DATE OF DEATH Month May Day 30 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/22/1885
9. AGE (In years) 81		10. IF UNDER 1 YEAR Months 15 Days 15 Hours 15 Min 15	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired: Stenographer & Sitter		10b. KIND OF BUSINESS OR INDUSTRY Baby	
11 BIRTHPLACE (County & State or foreign country) Eckhart Mines, Frostburg, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Alexander Close		14. MOTHER'S MAIDEN NAME Margaret Ferguson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT P.O. Box 599, Address Cumberland, Md. Allegany County Infirmary records.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Myocardial Infarction DUE TO (b) Parkinson's Disease DUE TO (c) chr. ASH-D with Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			INTERVAL BETWEEN ONSET AND DEATH 2 days 15 yrs 15 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from 9/29/64 , 19__, to 5/30/67 , 19__, that (I) (we) last saw the deceased alive on 5/29/67 , 19__, and that death occurred at A. M., from causes and on the date stated above.			
22a. SIGNATURE John A. Tupper		22b. DATE SIGNED 5/31/1967	
22c. PHYSICIAN'S NAME (Type) John A. Tupper, MD		22d. ADDRESS Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 6-1-1967	23c. NAME OF CEMETERY OR CREMATORY Eckhart	23d. LOCATION (City or town) (County) (State) Eckhart, Allegany, Md.
24. FUNERAL DIRECTOR Joseph R. Durd, Frostburg, Md.		25a. REC'D BY REGISTRAR JUN 2 1967	25b. REGISTRAR'S SIGNATURE Charles Judge



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

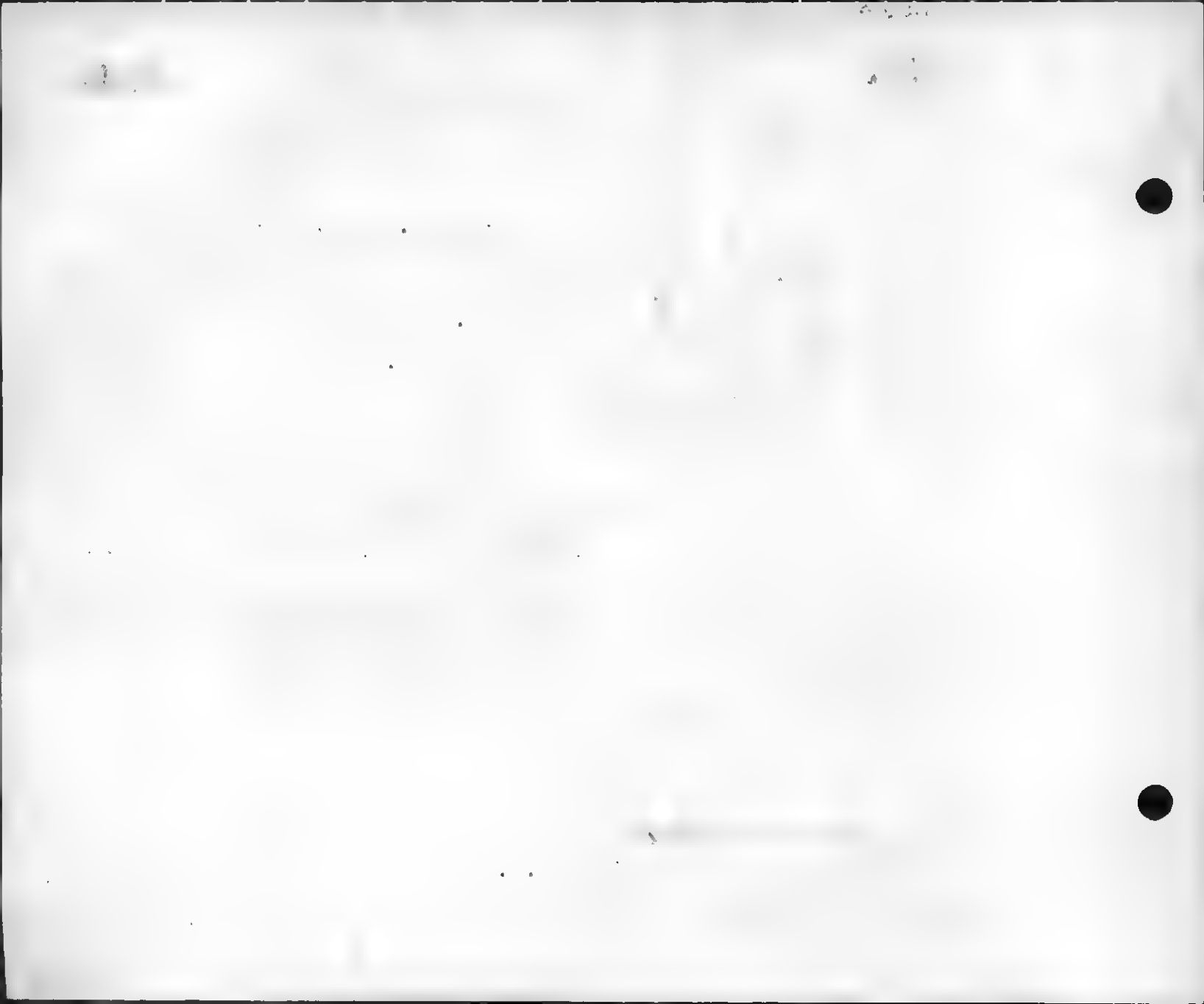
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06011

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06001

1. PLACE OF DEATH a. COUNTY Allogany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Pennsylvania b. COUNTY ✓	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN Ia DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Memorial Hospital		e. STREET ADDRESS 2130 E. 42nd. Street	
3. NAME OF DECEASED (Type or print) Annie Coffman		4. DATE OF DEATH May 2 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 18, 1894
9. AGE (in years last birthday) 72 yrs		10. F UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Penn.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME David Hunter		14. MOTHER'S MAIDEN NAME Mary Ramsey	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO None	
17. INFORMANT Mr. Edward Adams		Address Cumb. Md.	
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO (b) Coronary Sclerosis stating the underlying cause last. (c)		INTERVAL BETWEEN ONSET AND DEATH Sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Benedict Skitarelic M.D.		22. DATE SIGNED May 2, 1967	
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Assistant Medical Examiner <input type="checkbox"/>	
23a. B. RIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 5/5/67	
23c. NAME OF CEMETERY OR CREMATORY Lakeview Cem.		23d. LOCATION (City or town) (County) (State) Erre, Penna. (Erre Co)	
24. FUNERAL DIRECTOR Louis Stein Inc. Cumb. Md.		25a. REC'D BY REGISTRAR MAY 4 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06012

CERTIFICATE OF DEATH

05002

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG		c. LENGTH OF STAY IN 1b 6 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MINERS HOSPITAL		e. STREET ADDRESS 242 LOWER CONSOLIDATION	
3. NAME OF DECEASED (Type or print) MILLIE F. COSGROVE		4. DATE OF DEATH Month MAY Day 3 Year 1967	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 26, 1900
9. AGE (in years last birthday) 67 yrs		10. IF UNDER 1 YEAR Months 3 Days 19 Hours 67 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WORK		11. BIRTHPLACE (County & State, or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME BENJAMIN FILER	
14. MOTHER'S MAIDEN NAME RACHEL FOLK		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) 214-01-3683-A MRS. ROBT. BARR, FROSTBURG, MD.	
16. SOCIAL SECURITY NO. 214-01-3683-A		17. INFORMANT MRS. ROBT. BARR, FROSTBURG, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cancer of the Uterus - Fibroid DUE TO (b) 147.2 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NONE		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. ✓	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 5/3/67 , 19 66 , to 5/3 , 19 67 that (I) (we) last saw the deceased alive on 5/3 , 19 67 , and that death occurred at 8:45 A.M. , from causes and on the date stated above.			
22a. SIGNATURE Martin Rothstein M.D.		22b. DATE SIGNED 5/4/67	
22c. PHYSICIAN'S NAME (Type) MARTIN ROTHSTEIN, M. D.		22d. ADDRESS 48 BROADWAY, FROSTBURG, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF MAY 5, 1967	23c. NAME OF CEMETERY OR CREMATORY F.B.G. MEMORIAL PARK	23d. LOCATION (City or Town) (County) (State) FROSTBURG, MD.
24. FUNERAL DIRECTOR JOSEPH R. DURST, FROSTBURG, MD.		25a. REC'D BY REGISTRAR MAY 8 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove cards, papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

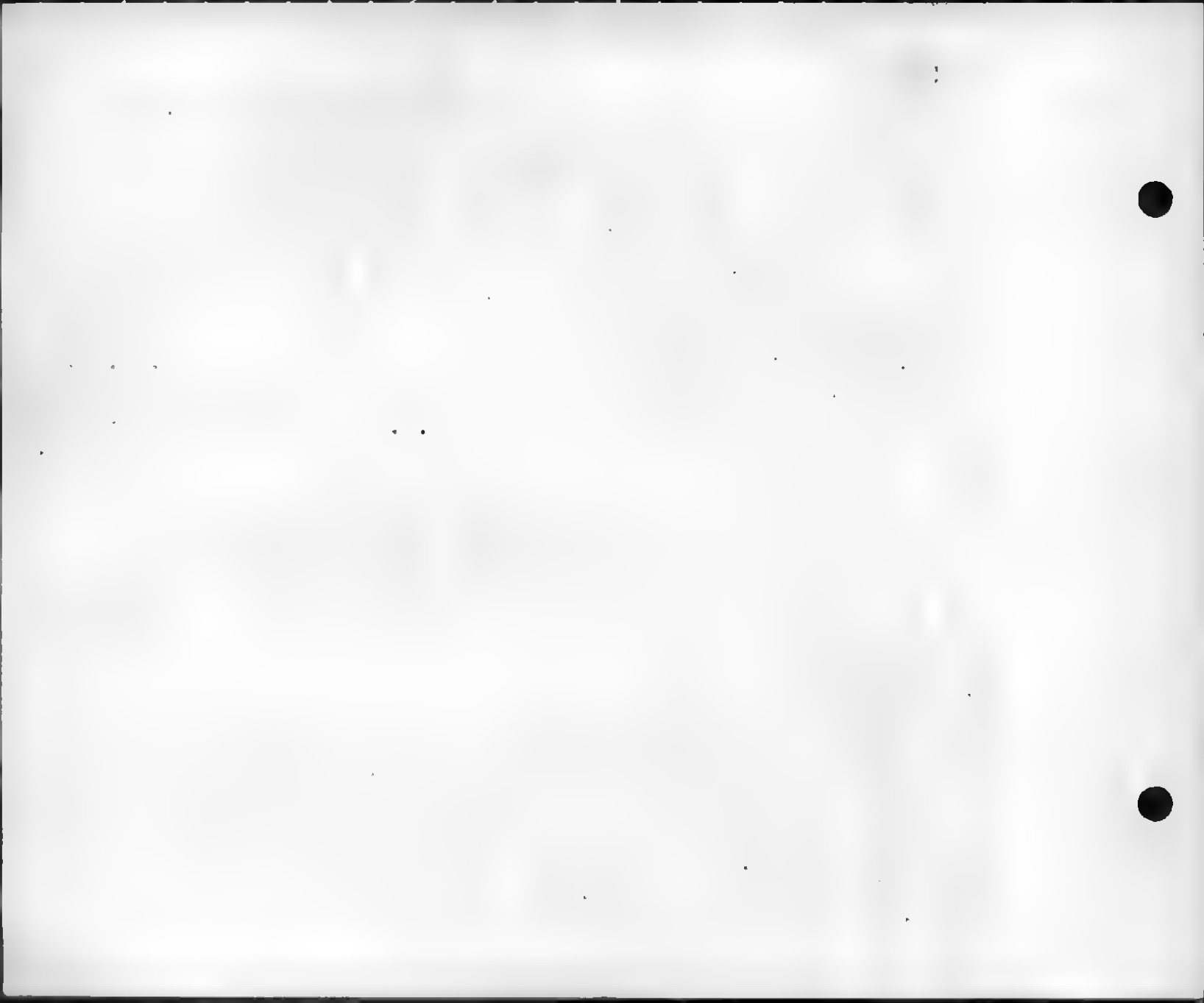
VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06013

CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN Ib 4/11/1967	
c. CITY OR TOWN (If outside corporate limits, write RJR and give nearest town) Cumberland			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Allegany County Infirmary		d. STREET ADDRESS 420 Holland Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) Thomas Bernard Cumiskey Jr.		4. DATE OF DEATH Month May Day 5 Year 1967	
5 SEX Male	6 COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 1/10/1884
9 AGE (in years last birthday) 83 yrs		IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired: Columbia Gas Company		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13 FATHER'S NAME William Cumiskey		14. MOTHER'S MAIDEN NAME Mary Rhodes Cumiskey	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT P.O. Box 599, Cumberland, Maryland		Allegany County Infirmary records.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Coronary Insufficiency DUE TO (b) Chronic Prostatic Hypertrophy with Prostatitis DUE TO (c) Chronic H.D. with Hypertension		INTERVAL BETWEEN ONSET AND DEATH approx. 10 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) A.S. Chronic Brain Encephalopathy. Aortic Stenosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April 11, 1967 , to May 5, 1967 , that (I) (we) last saw the deceased alive on May 5, 1967 , and that death occurred at 8:55 PM , from causes and on the date stated above.			
22a. SIGNATURE John A. Topper		22b. DATE SIGNED May 6 - 1967	
22c. PHYSICIAN'S NAME (Type) John A. Topper		22d. ADDRESS Hyndman, Pa.	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/9/67	
23c. NAME OF CEMETERY OR CREMATORY St. Peter & Paul Cem.		23d. LOCATION (City or Town) (County) (State) Cumberland MD	
24. FUNERAL DIRECTOR Louis Stein Inc. Camb. Md.		25a. REC'D BY REGISTRAR MAY 9 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any dissection is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 1, 2, and 3 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06014

26002

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE W.Va. b. COUNTY Hampshire	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Augusta	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Memorial Hospital		d. STREET ADDRESS 	
3. NAME OF DECEASED (Type or print) James Blake Davis		4. DATE OF DEATH Month May Day 4 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-2-50
9. AGE (In years last birthday) 17 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Frank Davis		14. MOTHER'S MAIDEN NAME Pauline Corbin	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Frank Davis		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock 1840 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO Extensive Body Burns (98%)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Driver of truck which overturned and caught fire	
20c. TIME OF INJURY Month, Day, Year 12:50 p.m. May 4 1967		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Junction Rt. 50 & 220 Near Keyser, W.Va.		20f. (City or town) (County) (State) W.Va.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Benedict Skitarelic M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
NAME (Type) BFNEDICT SKITARELIC, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/7/67	
22c. NAME OF CEMETERY OR CREMATORY Tearcoat Cemetery		22d. LOCATION (City, town, or country) (State) Cumberland, Md. W.Va.	
23. FUNERAL DIRECTOR Wade H. McKee		24a. REC'D BY REGISTRAR MAY 10 1967	
24b. REGISTRAR'S SIGNATURE Charles Judge		DATE SIGNED	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

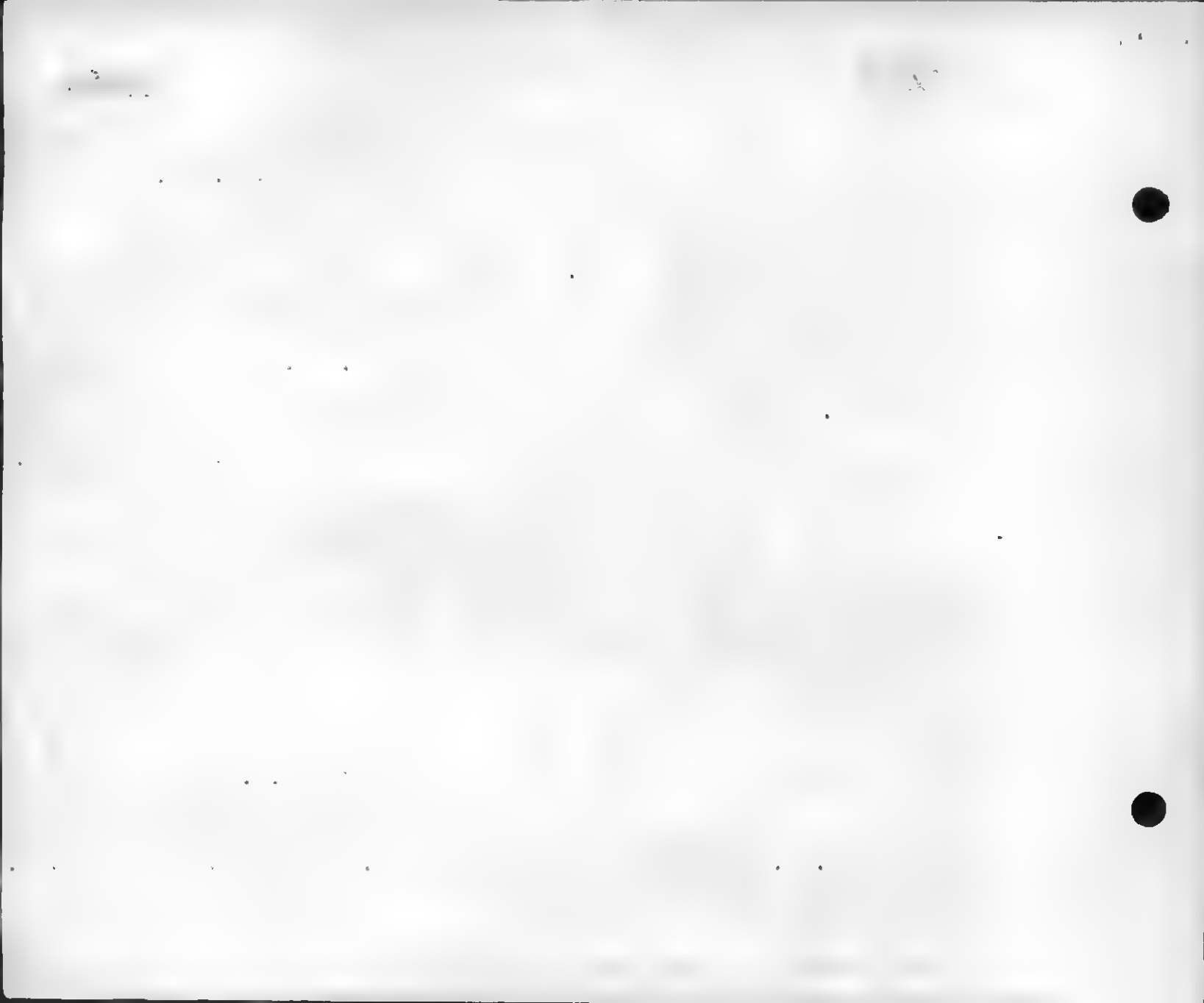
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06015

CERTIFICATE OF DEATH

06004

1 PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 4 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MOOREFIELD, W. VA.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL			d. STREET ADDRESS 311 ELM STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3 NAME OF DECEASED (Type or print) First MARION Middle H. Last DEAHL			4 DATE OF DEATH Month MAY Day 14 Year 19 67		
5 SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 12-10-1901	9 AGE (In years last birthday) 65 yrs	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED School Teacher		10b. KIND OF BUSINESS OR INDUSTRY Education		11. BIRTHPLACE (County & State, or foreign country) DAVIS, W. VA.	
13. FATHER'S NAME CALVIN J. DEAHL			14. MOTHER'S MAIDEN NAME SARAH HUFFMAN		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO		17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage with L. hemiplegia, etc. DUE TO Basal artery insufficiency DUE TO A.S. Cardiovascular disease with sten. A.S. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH 15 May 67 2 months ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Metastatic carcinoma 5 years					19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <input type="checkbox"/> p.m. <input type="checkbox"/> 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 10 May 1967 , to 14 May 1967 , that (I) (we) last saw the deceased alive on 13 May 1967 , and that death occurred at 3:55 AM , Acc. Mouses and on the date stated above.					
22a. SIGNATURE W. Alfred Van Ormer M.D.			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 14 May 67
22c. PHYSICIAN'S NAME (Type) W. A. VAN ORMER			22d. ADDRESS 122 SO. CENTRE ST. CUMBERLAND, MD.		
23a. BURIAL (CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF May 17, 1967	23c. NAME OF CEMETERY OR CREMATORY Olivet Cemetery		23d. LOCATION (City or Town) (County) (State) Moorefield, West Virginia	
24 FUNERAL DIRECTOR Thrush Funeral Home, Moorefield, West Virginia			25a. REC'D BY REGISTRAR MAY 25 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judge



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06016

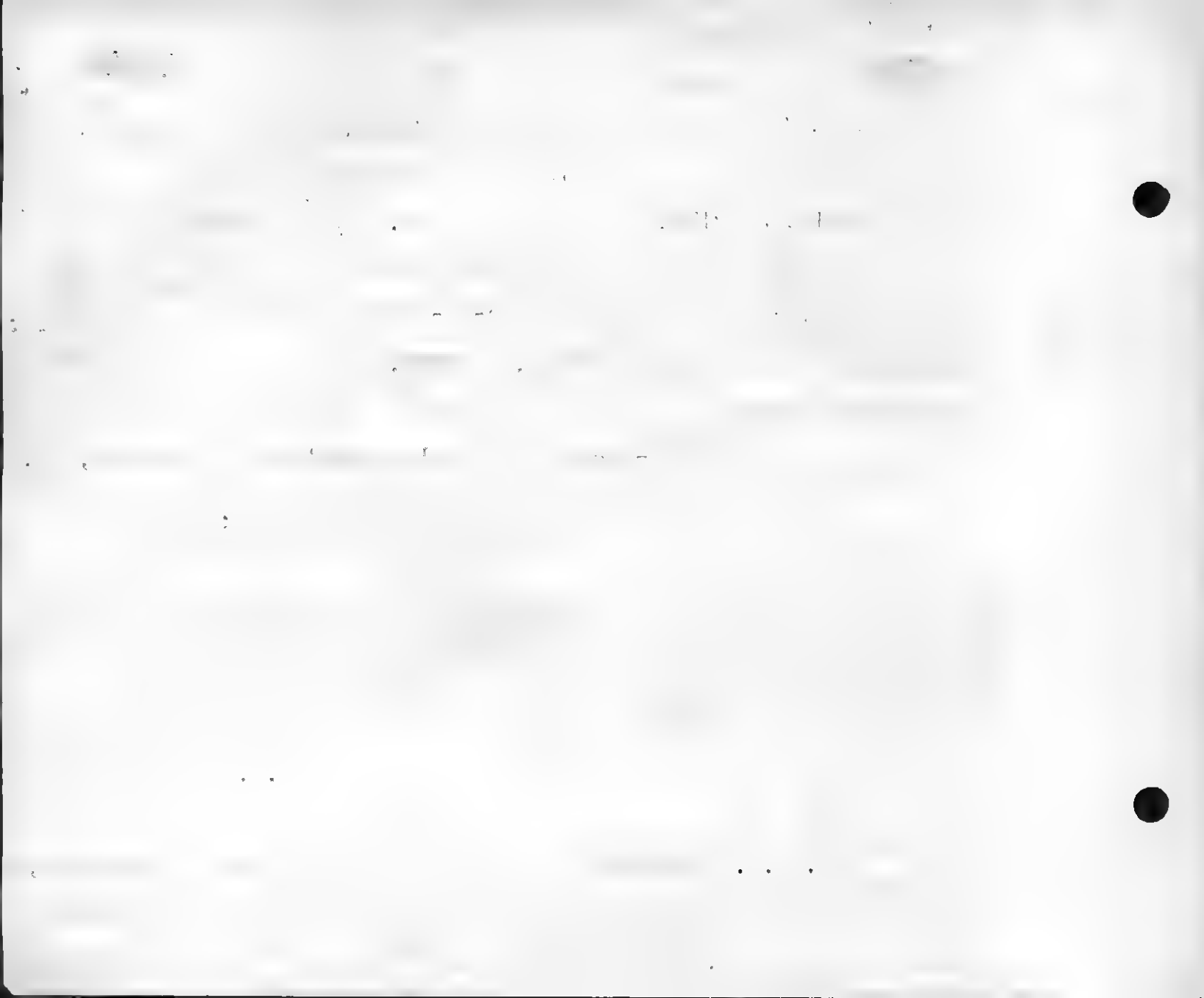
CERTIFICATE OF DEATH

06005

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove earlier papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY in lb 19 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		d. STREET ADDRESS BOX 229 RT. #2, FROSTBURG	
3 NAME OF DECEASED (Type or print) First Middle Last DURWARD DEFFENBAUGH		4 DATE OF DEATH Month Day Year MAY 7 19 67	
5 SEX MALE	6 COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-19-1903
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10b. KIND OF BUSINESS OR INDUSTRY KELLY TIRE CO.	9. AGE (In years lost birthday) 63 yrs
11. BIRTHPLACE (County & State, or foreign country) CUMBERLAND, MD.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME GEORGE DEFFENBAUGH		14. MOTHER'S MAIDEN NAME KATHRYN DICKEN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO 217-01-1575	
17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic carcinoma bone DUE TO Bronchogenic Carcinoma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) (d) 1621			INTERVAL BETWEEN ONSET AND DEATH ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Lungs Pathological fracture Neck, Left femur, Uremia, Metastatic Disease			9. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 4/1/67 , 19__ to 5/7/67 , 19__, that (I) (we) last saw the deceased alive on May 7, 19 67 , and that death occurred at 1:55 A.M. on the date stated above.			
22a. SIGNATURE <i>Dr. S.M. Jacobson</i>		22b. DATE SIGNED 5/8/67	
22c. PHYSICIAN'S NAME (Type) DR. S.M. JACOBSON		22d. ADDRESS 50 PERSHING STREET, CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF MAY 10, 1967	23c. NAME OF CEMETERY OR CREMATORY FROSTBURG MEM. PARK	23d. LOCATION (City or Town) (County) (State) FROSTBURG MARYLAND
24. FUNERAL DIRECTOR MILLOU M. SOWERS		25. REC'D BY REGISTRAR 11 1967	
26. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		27. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

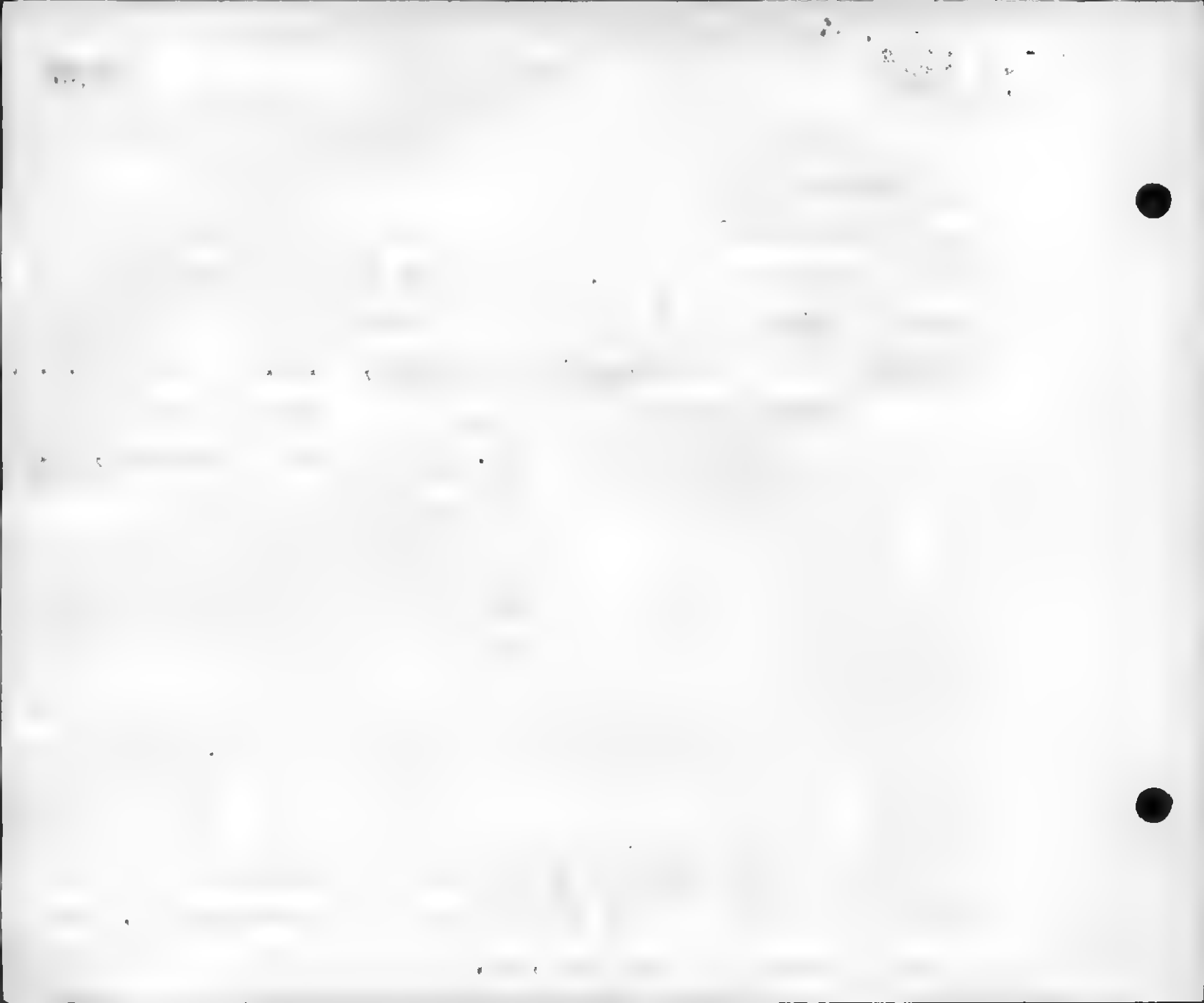
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY Allegany MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut an: Residence before adm ssion) a. STATE Maryland b. COUNTY Allegany	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c LENGTH OF STAY IN 1b Lonaconing	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Miners Hospital		d STREET ADDRESS State Street	
3 NAME OF DECEASED (Type or print) First Edward Middle L. Last Elkins		4 DATE OF DEATH Month May Day 29 Year 1967	
5 SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/8/1904
9. AGE (In years last birthday) 62 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	
10b. KIND OF BUSINESS OR INDUSTRY Construction		11 BIRTHPLACE (County & State, or foreign country) Keyser, W. Va.	
12 CITIZEN OF WHAT COUNTRY? U.S.A.		13 FATHER'S NAME Joseph Elkins	
14 MOTHER'S MAIDEN NAME Mary Ann Gay		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	
16 SOCIAL SECURITY NO		17 INFORMANT Mrs. Gladys Elkins Address Lonaconing, Md.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute coronary occlusion 4/201 DUE TO (b) Coronary Insufficiency Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) Arteriosclerosis - generalized		INTERVAL BETWEEN ONSET AND DEATH 1 yr. 1 mo.	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Uncontrolled diabetes mellitus - acidosis		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1960 to May 29, 1967 , that (I) (we) last saw the deceased alive on May 29, 1967 , and that death occurred at 2 p.m. , from causes and on the date stated above.			
22a SIGNATURE L. R. Miles Jr. M.D.		22b DATE SIGNED 5-29-67	
22c PHYSICIAN'S NAME (Type) L. R. MILES, JR., M.D.		22d ADDRESS LONA CONING MD.	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF 6/1/67	
23c NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery		23d LOCATION (City or Town) (County) (State) Lonaconing A. Md	
24 FUNERAL DIRECTOR George Eichhorn		25a REC'D BY REG STRAR MAY 31 1967	
25b REGISTRAR'S SIGNATURE Charles Judge			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

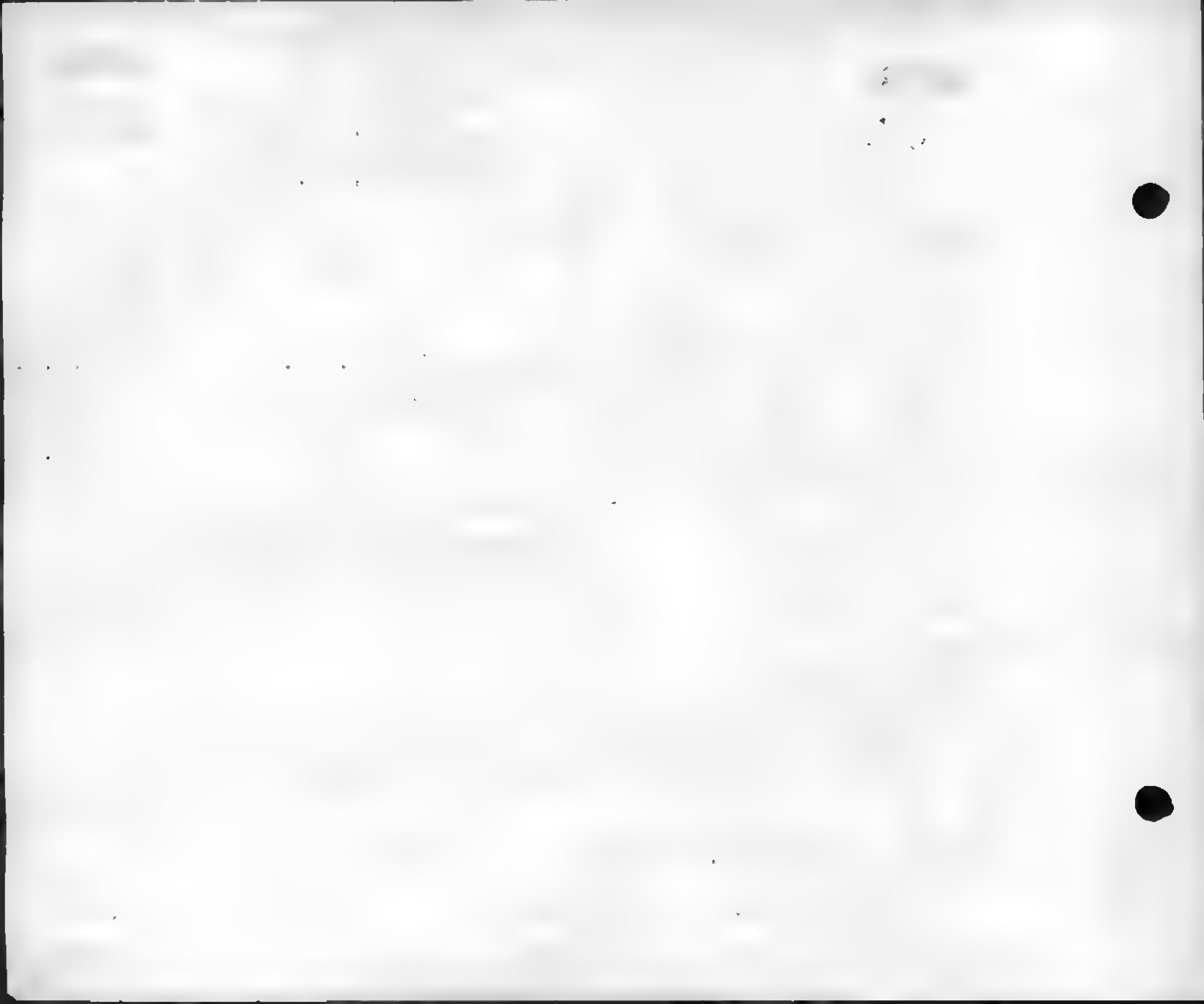
CERTIFICATE OF DEATH

06007

06018

1 PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Res. den. before admission) a. STATE PENNA. b. COUNTY SOMERSET/ BEDFORD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 3 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		e. STREET ADDRESS RD#1	
3 NAME OF DECEASED (Type or print) First CLARENCE Middle B Last EMERICK		4 DATE OF DEATH Month MAY Day 28 Year 1967	
5 SEX MALE	6 COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-14-77
9 AGE (In years last birthday) 89		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	
10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State, or foreign country) HYNDMAN, PA.	
12 CITIZEN OF WHAT COUNTRY? U.S.A.		13 FATHER'S NAME JOHN L. EMERICK	
14 MOTHER'S MAIDEN NAME ELIZABETH BONELL		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	
16 SOCIAL SECURITY NO 213-40-2879		17 INFORMANT Address MEMORIAL HOSPITAL CUMBERLAND, MD.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Congestive Heart Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 4 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Advanced pulmonary emphysema			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from MAY 1964 to MAY 28, 1967 , that (I) (we) last saw the deceased alive on 5-28-1967 , and that death occurred at 11:35A M, from causes and on the date stated above.			
22a. SIGNATURE William P. James		22b. DATE SIGNED 5/29/67	
22c. PHYSICIAN'S NAME (Type) DR. W. P. JAMES		22d. ADDRESS CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF May 31, 1967	23c. NAME OF CEMETERY OR CREMATORY Comps Cemetery	23d. LOCATION (City or Town) (County) (State) Hyndman, Somerset Co., Pa. RD#1
24. FUNERAL DIRECTOR Harvey H. Feigler		25a. REC'D BY REGISTRAR JUN 5 1967	
ADDRESS Hyndman, Pennsylvania		25b. REGISTRAR'S SIGNATURE Charles Judge	

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

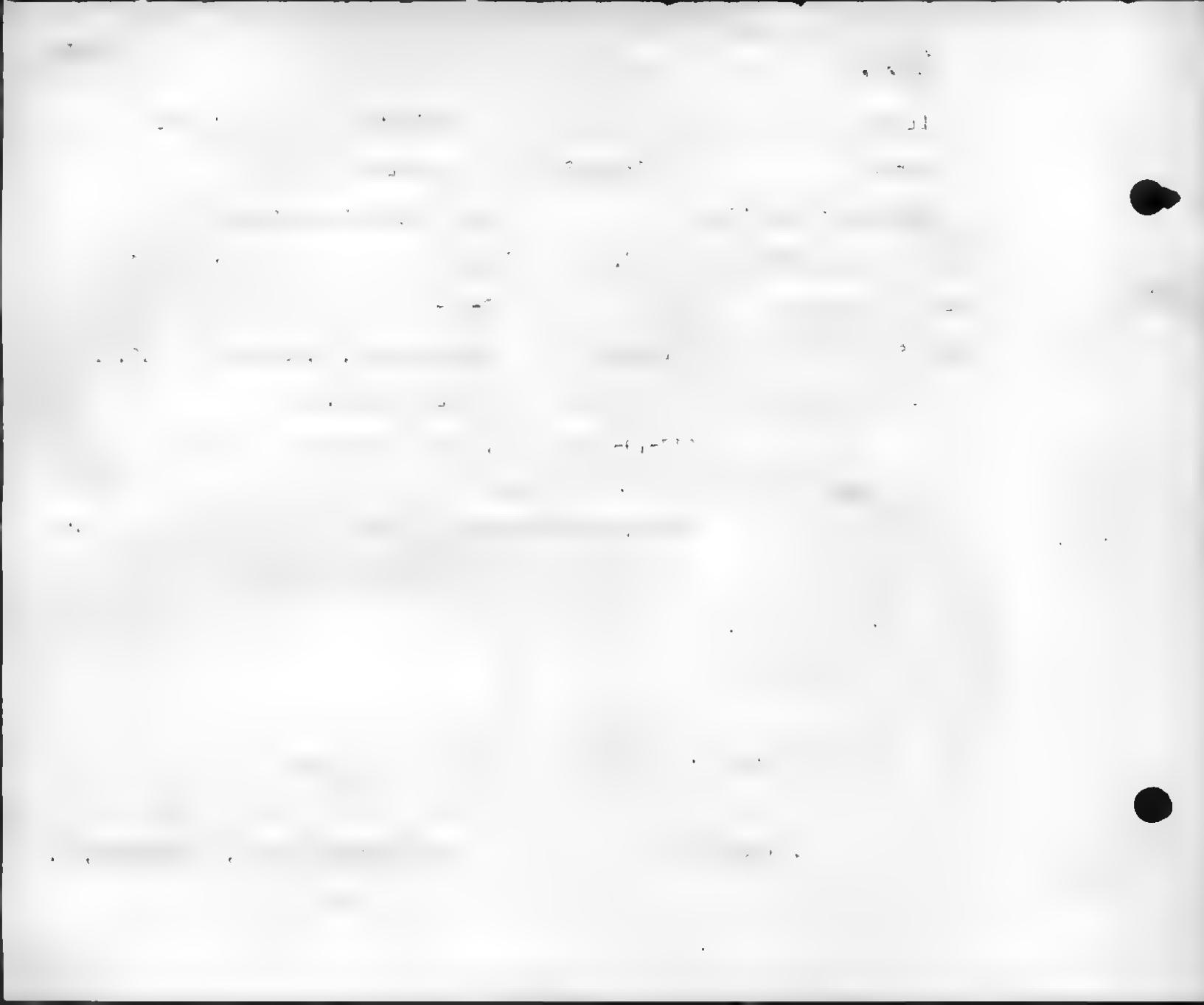
06013

Item #9 Film 2537-17-15

CERTIFICATE OF DEATH

35708

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN 1b 16 DAYS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SACRED HEART HOSPITAL				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND d. STREET ADDRESS 507 PRINCE GEORGE STREET e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last JOHN J. FOLEY			4. DATE OF DEATH Month Day Year MAY 14 19 67				
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH 07-27-92		9. AGE (In years last birthday) 74 7/8 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PLANT SUPERVISER		10b. KIND OF BUSINESS OR INDUSTRY CELANESE		11. BIRTHPLACE (County & State, or foreign country) WESTERNPORT, MD. ALLEGANY			
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME WILLIAM Foley					
14. MOTHER'S MAIDEN NAME ELLEN (HOBAN)		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO					
16. SOCIAL SECURITY NO. 217-10-4980		17. INFORMANT PATIENTS HOSP RECORD SHH					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL FAILURE DUE TO (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) PULMONARY EMBOLISM-BRONCHITIS-EMPHYSEMA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH 2 WKS. 20 YRS. 5 DAYS		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) PERFORATED DUODENAL ULCER WITH PERTONITIS							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) NONE					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) NONE			
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from APRIL 29, 19 67 to MAY 14, 19 67 that (I) (we) last saw the deceased alive on MAY 14, 19 67 , and that death occurred at 5:10 AM from the causes and on the date stated above.							
22a. SIGNATURE <i>James F. Scarpe'li</i>		22b. PHYSICIAN'S NAME (Type) DR. HALLINAN		22c. DATE SIGNED 5-15-67			
22d. ADDRESS 140 BEDFORD STREET, CUMBERLAND, MD.							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF May 16, 1967		23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery			
23d. LOCATION (City, town or county) (State) Cumberland, Md. Allegany							
24. FUNERAL DIRECTOR James F. Scarpe'li, Cumberland, Md.		25a. REC'D BY REGISTRAR MAY 17 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



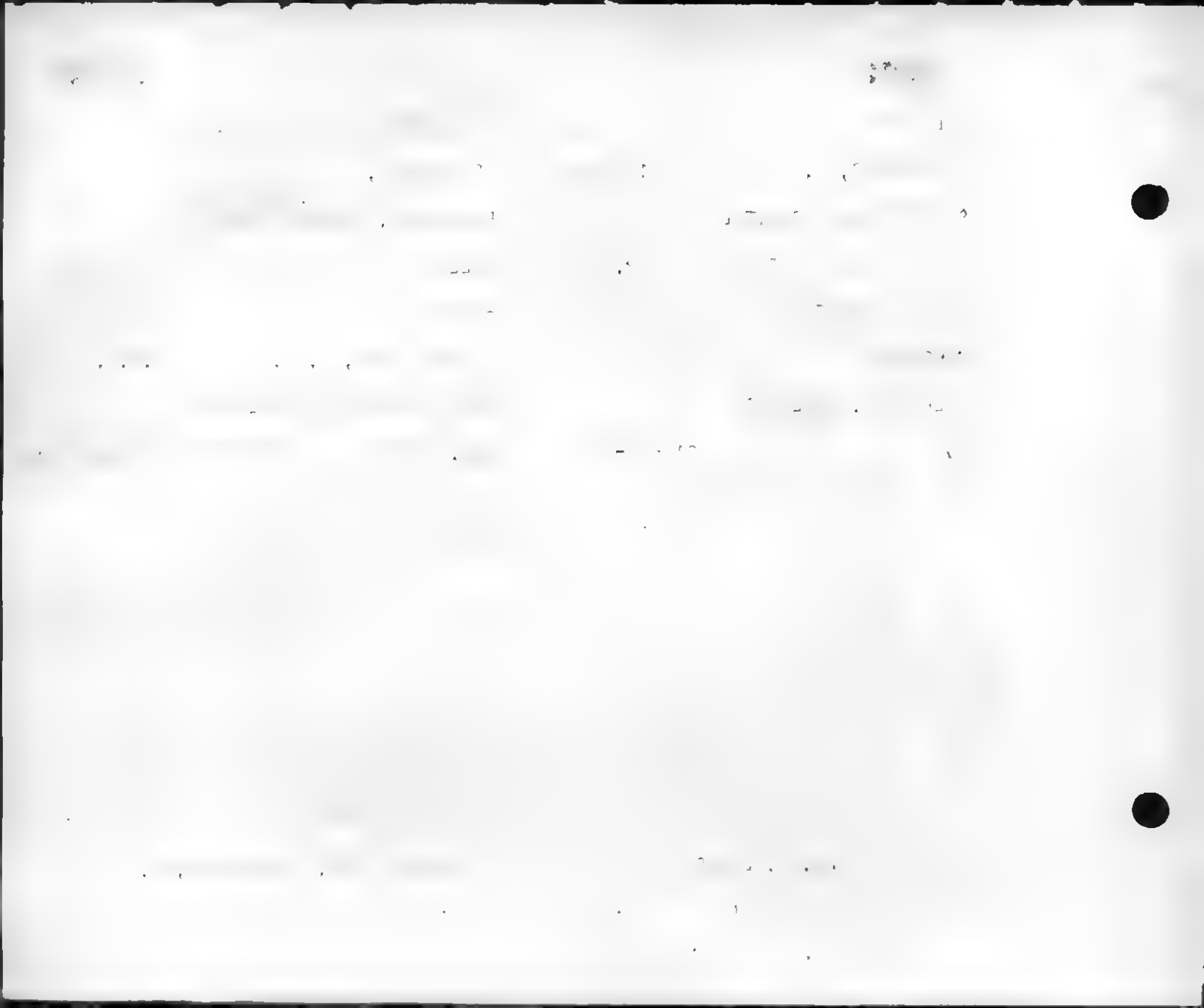
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05005

1. PLACE OF DEATH a. COUNTY ALLEGANY						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND MD.						c. LENGTH OF STAY IN ID 13 DAYS					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SACRED HEART HSOPITAL						e. STREET ADDRESS FROSTBURG, 95 BRADDOCK STREET FROSTBURG, MARYLAND 21532					
3. NAME OF DECEASED (Type or print) First Middle Last ETHA P. FULLER						4. DATE OF DEATH Month Day Year MAY 6 1967					
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-9-1894		9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE						10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) LAUREL DALE, W.VA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM H. WALLBOTT						14. MOTHER'S MAIDEN NAME SYNTHY (BURGESS) WALLBOTT					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO						16. SOCIAL SECURITY NO. 217-05-7655		17. INFORMANT Address HOSP. RECORD SACRED HEART HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive coronary occlusion DUE TO (b) Anteroseptal C. V. D. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Surgery May 1, 1967 - cholecystectomy + umbilical hernia repair											
INTERVAL BETWEEN ONSET AND DEATH minutes years											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 4/23, 1967 , to 5/6, 1967 , that (I) (we) last saw the deceased alive on 5/5, 1967 , and that death occurred at 6 AM , from the causes and on the date stated above.											
22a. SIGNATURE Thomas J Lewis						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 5/6/67			
22c. PHYSICIAN'S NAME (Type) DR. T. LEWIS						22d. ADDRESS 500 GREEN ST. CUMBERLAND MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF MAY 8 '67		23c. NAME OF CEMETERY OR CREMATORY FBG. MEMORIAL PARK		23d. LOCATION (City, town or county) (State) FROSTBURG, MD.					
24. FUNERAL DIRECTOR ADDRESS JOSEPH R. DURST, SR., FROSTBURG, MD.						25a. REC'D BY REGISTRAR MAY 9 1967		25b. REGISTRAR'S SIGNATURE [Signature]			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

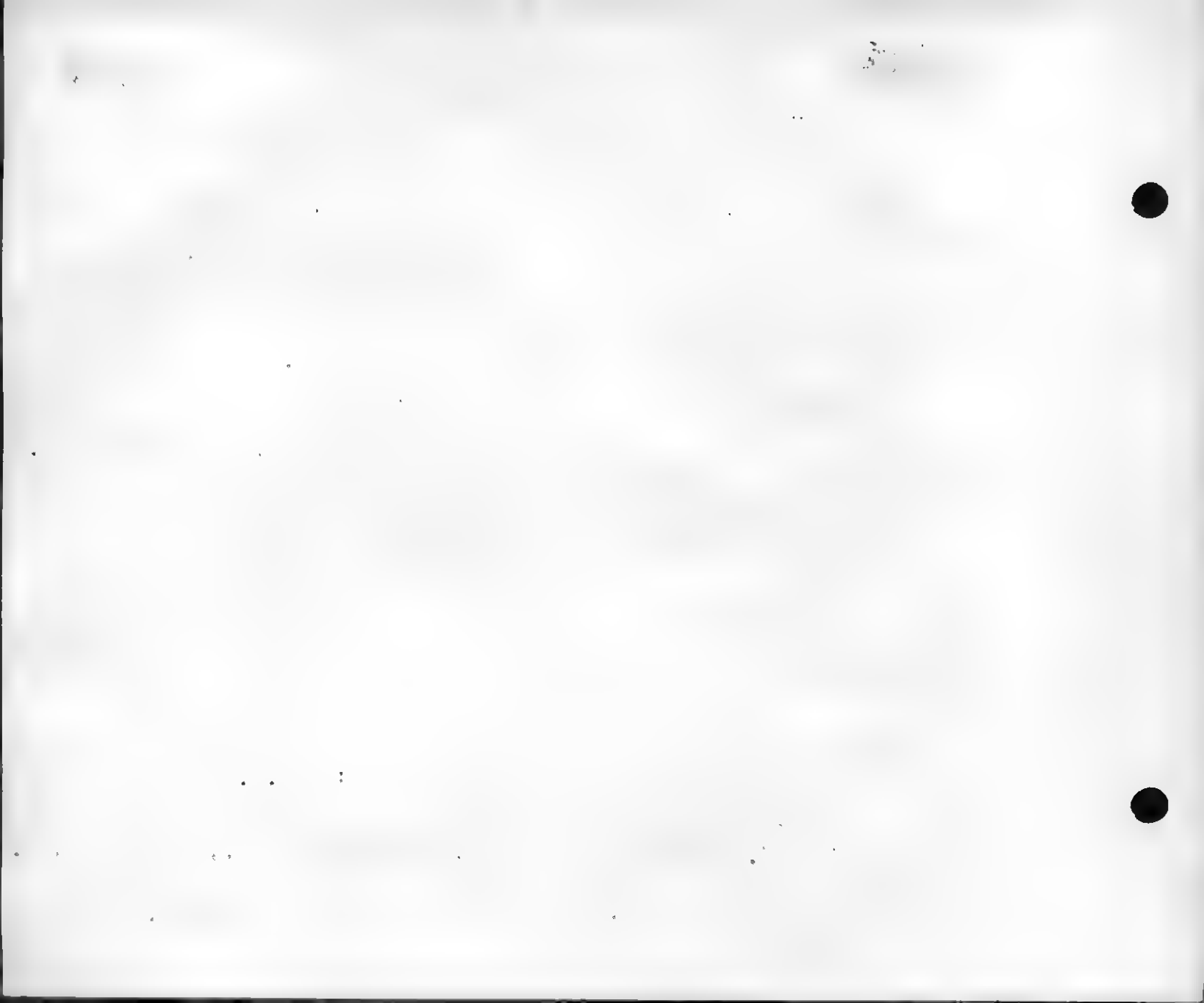
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06021

CERTIFICATE OF DEATH

06010

1 PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c LENGTH OF STAY in 1b 6 DAY 9 HR	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		d STREET ADDRESS 513 VIRGINIA AVENUE	
3 NAME OF DECEASED (Type or print) First JOHN Middle FULTON Last FULTON		4 DATE OF DEATH Month MAY Day 10 Year 1967	
5 SEX MALE	6 COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 3-30-1882
9. AGE (In years lost birthday) 85 yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b KIND OF BUSINESS OR INDUSTRY RETIRED	
11 BIRTHPLACE (County & State, or foreign country) BROADTOP, PENNA.		12 C T ZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME IRVIN FULTON		14. MOTHER'S MAIDEN NAME BRIGID LAVELLE	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give war or dates of service)		16 SOCIAL SECURITY NO 216-22-6298	
17 INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Upper Respiratory Infection DUE TO Probable Granulomatous Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Myocarditis & Decompensation (c) 1 yr			INTERVAL BETWEEN ONSET AND DEATH 7
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour 'o.m. p.m. 19	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from May 7, 1967 , to May 16, 1967 , that (I) (we) last saw the deceased alive on May 16, 1967 , and that death occurred at 11:25 p.m. on the date stated above.			
22a SIGNATURE Clay E. Durrett M.D.		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22b DATE SIGNED May 13, 1967
22c PHYSICIAN'S NAME (Type) CLAY E. DURRETT		22d ADDRESS 236 VIRGINIA AVE., CUMBERLAND, MD.	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF May 13, 1967	23c NAME OF CEMETERY OR CREMATORY SS. Peter & Paul Cemetery Cumberland Md. Allegany	
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		25a REC'D BY REGISTRAR MAY 17 1967	25b REGISTRAR'S SIGNATURE Charles J. J...



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06022

CERTIFICATE OF DEATH

00011

1 PLACE OF DEATH a. COUNTY Allegany b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Md. b. COUNTY Allegany	
c. LENGTH OF STAY IN 1b 70 Yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 115 Spruce St.		d. STREET ADDRESS 115 Spruce	
3 NAME OF DECEASED (Type or print) First Middle Last Lawrence Elmer Gales		4 DATE OF DEATH Month Day Year May 15 1967	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 16m 1890
9 AGE (In years last birthday) 76 yrs		10. IF UNDER 1 YEAR Months Days 15 167	
10a. USUA. OCCUPATION (Give kind of work done during most of work ng life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Paper Mill	
11 BIRTHPLACE (County & State, or foreign country) Mineral-W.Va.		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George W. Gales		14. MOTHER'S MAIDEN NAME Addie Whithair	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) If yes give war or dates of service) Yes W.W. I		16 SOCIAL SECURITY NO 212-12-842	
17 INFORMANT Angie Gales Burgess-Westernport, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocarditis with Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost Chronic Bronchitis with Asthma DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 5 Years 20 Years	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Feb. 4, 1963 , to May 15, 1967 , that (I) (we) last saw the deceased alive on May 14, 1967 , and that death occurred at 5:30 AM , from causes and on the date stated above.			
22a SIGNATURE Paul R. Wilson		22b DATE SIGNED May 15, 1967	
22c PHYSICIAN'S NAME (Type) Paul R. Wilson		22d ADDRESS Piedmont, W.Va.	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5/17/67	23c. NAME OF CEMETERY OR CREMATORY Philos	23d LOCATION (City or Town) (County) (State) Westernport Md.
24. FUNERAL DIRECTOR E. J. Bral		25a. REC'D BY REGISTRAR DATE MAY 18 1967	
ADDRESS Westernport, Md.		25b REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06023

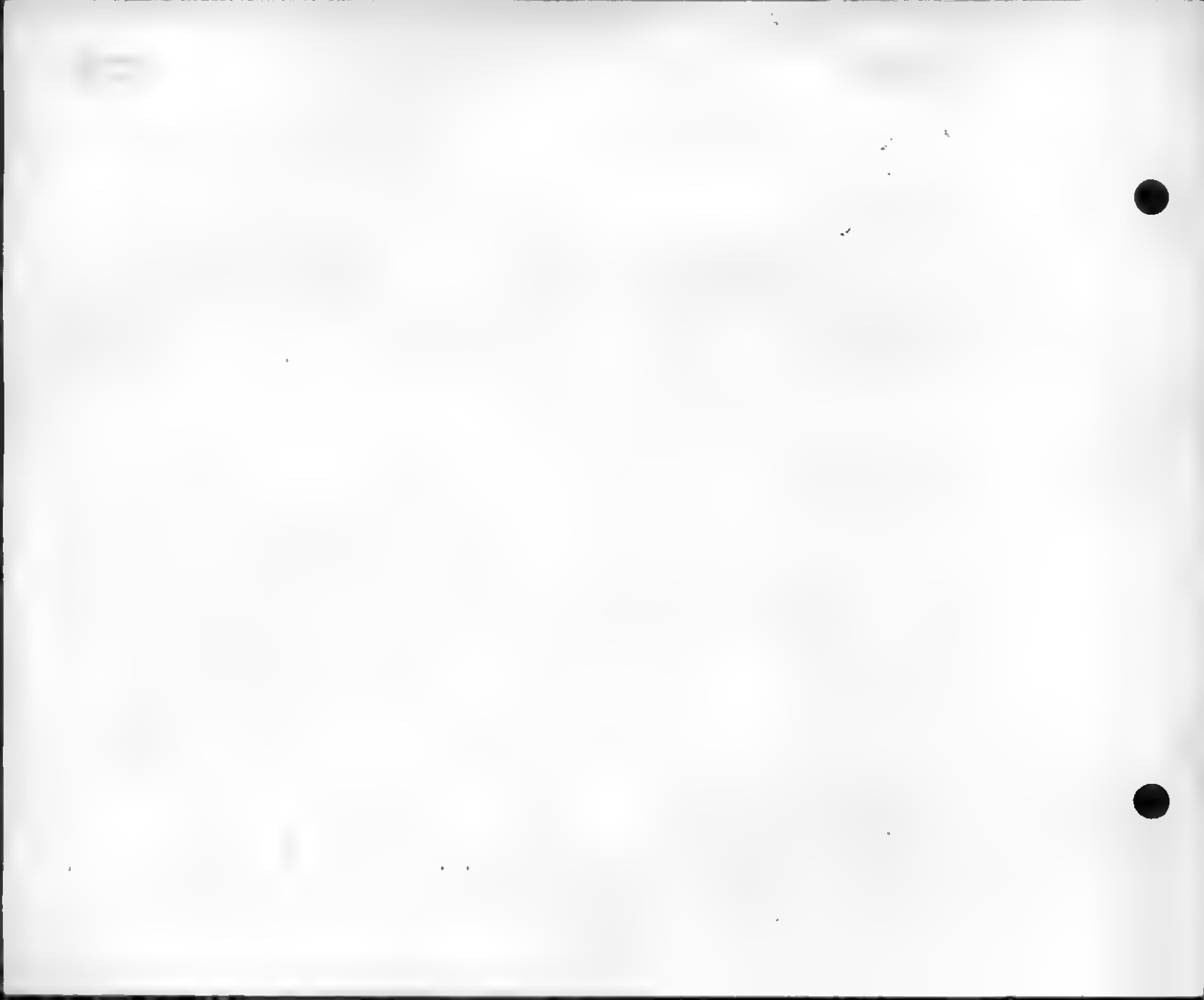
06012

FOR STATE
HEALTH DEPT.

1 PLACE OF DEATH a COUNTY Allegany MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution or Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c LENGTH OF STAY IN TB 69 years	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 19 Boone Street		d STREET ADDRESS 19 Boone Street	
3 NAME OF DECEASED (Type or print) Sarah (Sadie) Hansrote		4 DATE OF DEATH Month May Day 19 Year 1967	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W DOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Oct. 4, 1897
9 AGE (In years lost birthday) 69 yrs		IF UNDER 1 YEAR Months 19 Days 19 Hours 67 Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b KIND OF BUSINESS OR INDUSTRY Own Home	
11 BIRTHPLACE (State or foreign country) Cumberland Md.		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME Emanuel Beal		14 MOTHER'S MAIDEN NAME Sarah Beal	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16 SOCIAL SECURITY NO Mr. Wilbur Hansrote, Cumberland, Md. Son	
17 INFORMANT Mr. Wilbur Hansrote, Cumberland, Md. Son		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4201 DUE TO CORONARY OCCLUSION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO CORONARY SCLEROSIS (c)		INTERVAL BETWEEN ONSET AND DEATH SUDDEN	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS A TOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day Year Hour a.m. 19 p.m.		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e PLACE OF INJURY (Home, farm, factory, street, office, bag, etc.)		20f (City or town, county, state)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Benedict Skitarelic</i> M.D.		22. DATE SIGNED May 19, 1967	
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF May 22, 1967	
23c NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d LOCATION (City or town, county, state) Cumberland, Md. Allegany	
24 FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		25a REC'D BY REGISTRAR MAY 23 1967	
		25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PW-100. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06024

CERTIFICATE OF DEATH

06013

1 PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE WEST VIRGINIA COUNTY <input checked="" type="checkbox"/>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 11 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hosp.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PETERSBURG, WEST VIRGINIA	
f. STREET ADDRESS 9 NORTH MAIN ST.		g. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First MIMA Middle P Last HARPER		4 DATE OF DEATH Month MAY Day 29 Year 19 67	
5 SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-2-92
9 AGE (n years lost birthday) yrs 75		10. F UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) WEST VIRGINIA		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME TRUMAN PARSON		14. MOTHER'S MAIDEN NAME VIRGINIA HYRE	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT MEMORIAL HOSPITAL		Address CUMBERLAND, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia - Arterio sclerotic DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Vascular disease for advanced DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Osteoarthritis - joints of fingers & large joints		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) Janitor	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5-18-67 to 5-29-67 that (I) (we) last saw the deceased alive on 5-28-1967 , and that death occurred at 8:15 A.M. from causes and on the date stated above			
22a. SIGNATURE Wm. F. Williams M.D.		22b DATE SIGNED	
22c PHYSICIAN'S NAME (Type) DR. W. F. WILLIAMS		22d ADDRESS 122 S. CENTRE ST., CUMBERLAND, MD.	
23a BURIAL, CREMATION, REMOVAL (Specify) Buried		23b. DATE THEREOF May 31-1967	
23c NAME OF CEMETERY OR CREMATORY Maple Hill Cemetery		23d LOCATION (City or Town) (County) (State) Petersburg - Grant W. Va.	
24 FUNERAL DIRECTOR William B. Knight - Cumberland Md.		25a REC'D BY REGISTRAR DATE JUN 2 1967	
25b REGISTRAR'S SIGNATURE Blanche Judge			

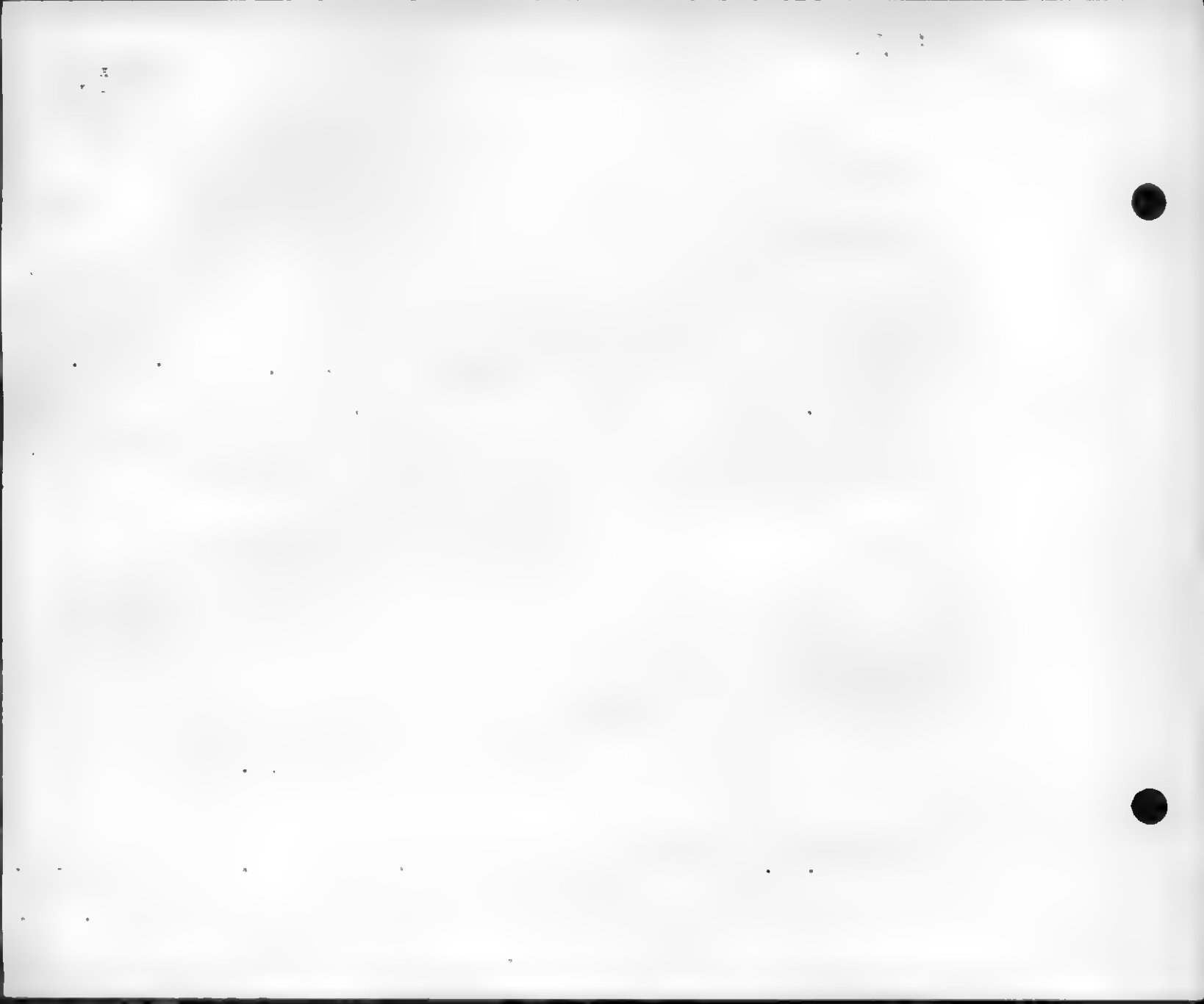


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
06025											
Item #2 taken from Birth Certificate of DEATH											
06014											
1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) <input checked="" type="checkbox"/> a. STATE MARYLAND b. COUNTY ALLEGANY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN IB 48 MINUTES		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND Rockwood					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL						d. STREET ADDRESS 673 Main Street 125 GRAND AVENUE				e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First BABy Middle GIrl Last HELM						4. DATE OF DEATH Month MAY Day 12 Year 1967					
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MAY 12, 1967		9. AGE (n years lost birthday) yrs 48		IF UNDER 1 YEAR Months Days Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none				10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (County & State, or foreign country) CUMBERLAND, MD.				12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME DONALD E. HELM						14. MOTHER'S MAIDEN NAME LINDA L. PHILLIPPI					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO		17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.					
18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 116X DUE TO premature labor - 5 1/2 hours Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) DUE TO (c) DUE TO						INTERVAL BETWEEN ONSET AND DEATH 4 1/2 hours					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 197-20 A.M. , 19 67 , that (I) (we) last saw the deceased alive on 19 , and that death occurred at 7:20 M, from causes and on the date stated above.											
22a. SIGNATURE W. Royce Hodges						22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) DR. W. ROYCE HODGES			
22d. ADDRESS 122 S. CENTRE ST., CUMBERLAND, MD.											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF May 13, 1967		23c. NAME OF CEMETERY OR CREMATORY Restlawn Memorial Park, Near Ia Vale, Md. All.				23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.						25a. REC'D BY REGISTRAR MAY 17 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in only event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06026

CERTIFICATE OF DEATH

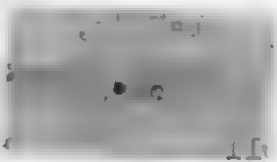
06015

1 PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY in 1b 4 DAYS		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		d. STREET ADDRESS 224 HARRISON ST.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First BERTIE Middle M. Last HELMICK		4 DATE OF DEATH Month MAY Day 11 Year 19 67		5 SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8 DATE OF BIRTH 5-1-1897		9 AGE (n years lost birthday) yrs 70		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY At Home		11 BIRTHPLACE (County & State or foreign country) LOST RIVER, WVA.	
12 CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME SIMON HELMICK RIGGLEMAN		14. MOTHER'S MAIDEN NAME LOUISE WHETZEL		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO 218-30-2318D	
17 INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.		18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure DUE TO Myocardial Infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Artery Disease DUE TO Atherosclerosis (c) Hypertension		INTERVAL BETWEEN ONSET AND DEATH 1 day		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) See above	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour 11 of Day PM		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Cumberland City, MD	
21. I certify that (I) (this hospital) attended the deceased from 5/7/67 , 19 67 , at 7:05 P.M. , and that death occurred on 5/11/67 , 19 67 , at 11:00 A.M. , from causes and on the date stated above.		22a. SIGNATURE DR. R. J. WILLIAMS		22b. DATE SIGNED 5/17/67		22c. PHYSICIAN'S NAME (Type) DR. R. J. WILLIAMS		22d. ADDRESS CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/14/67		23c. NAME OF CEMETERY OR CREMATORY Biertown Cemetery		23d. LOCATION (City or Town) (County) (State) Rawlings Allegany Maryland		24. FUNERAL DIRECTOR H. Lee Silcox Cumberland Maryland 21502	
25a. REC'D BY REG STRAR MAY 16 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judge		25c. REGISTRAR'S NAME J. Charles Judge		25d. REGISTRAR'S ADDRESS J. Charles Judge		25e. REGISTRAR'S PHONE J. Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
06027					CERTIFICATE OF DEATH					06016	
1. PLACE OF DEATH a. COUNTY Allegany MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland			c. LENGTH OF STAY IN 1b 4/23/1965		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LaVale,						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Allegany County Infirmary					d. STREET ADDRESS 30 McKenzie Rd.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Earl Robert Herrell					4. DATE OF DEATH May 17, 1967						
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/27/1902		9. AGE (In years last birthday) yrs 65		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) RETIRED: Colanese (Spinning Dept.)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Largent, W. Va.			12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME Unknown,					14. MOTHER'S MAIDEN NAME Lucy Herrell						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO 217-10-6980		17. INFORMANT P.O. Box 599, Cumberland, Md. Allegany County Infirmary records.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO (b) Generalized Atherosclerosis DUE TO (c) Parkinson's Disease										INTERVAL BETWEEN ONSET AND DEATH yes	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 4/23/1965 to 5/17/1967 , that (I) (we) last saw the deceased alive on 5/16/1967 , and that death occurred at A. M. from causes and on the date stated above. at 1:45 A. M.											
22a. SIGNATURE George M. Simons				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>				22b. DATE SIGNED 5/17/1967			
22c. PHYSICIAN'S NAME (Type) George M. Simons, M. D.				22d. ADDRESS Memorial Hosp. Cumberland, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/19/67		23c. NAME OF CEMETERY OR CREMATORY Davis Memorial Park			23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany Md.				
24. FUNERAL DIRECTOR H. Wayne George Cumberland, Maryland						25a. REC'D BY REGISTRAR MAY 22 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			



stop*oh

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

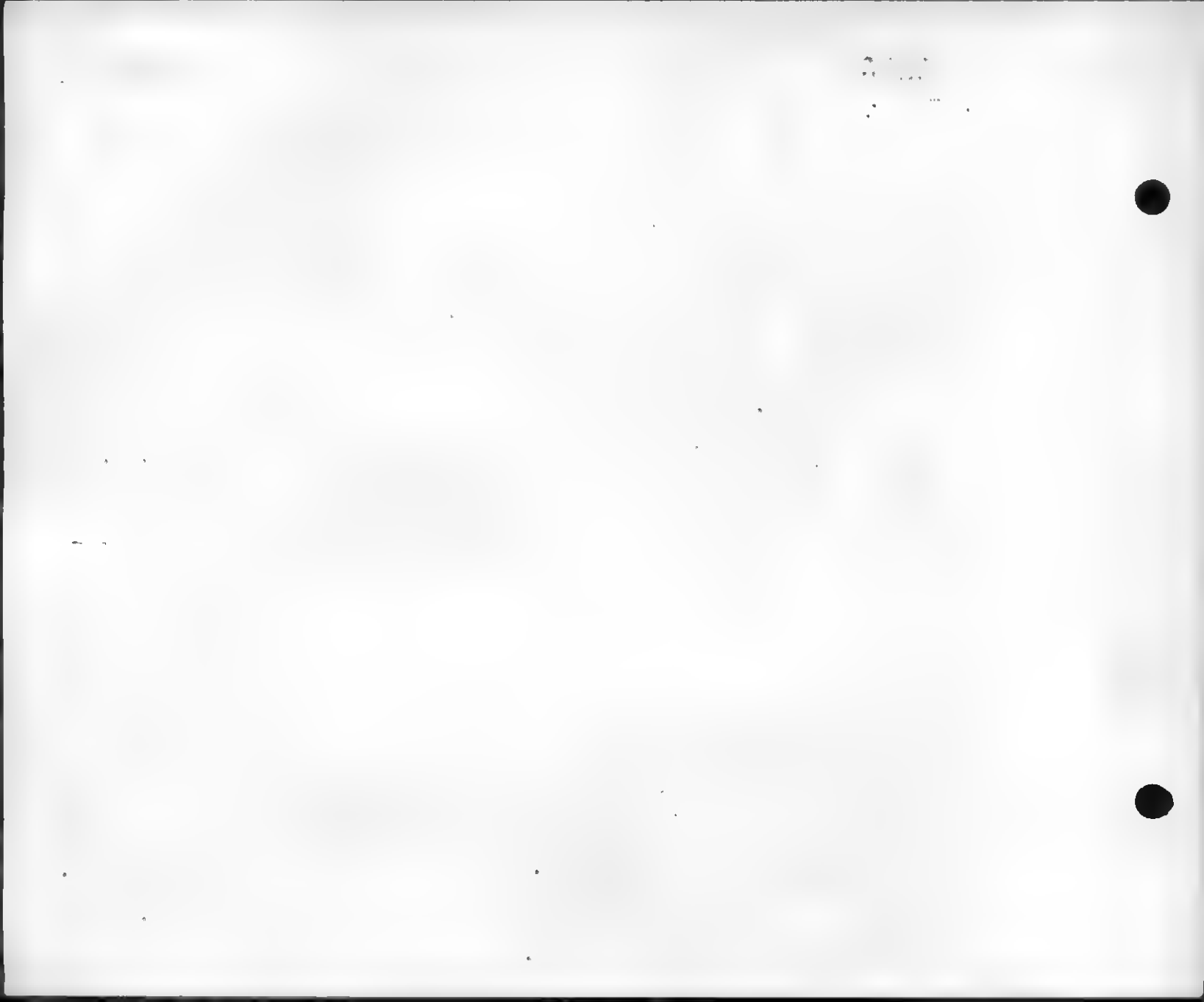
06028

06017

1 DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a COUNTY Allegany MARYLAND				2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a STATE Maryland b COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c LENGTH OF STAY in b 50 years			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 607 Sedgewick Street				d STREET ADDRESS 607 Sedgewick Street			
3 NAME OF DECEASED (Type or print) First Charles Middle Z. Last Heskett				4 DATE OF DEATH Month May Day 5 Year 1967			
5 SEX Male		6 COLOR OR RACE White		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH Oct. 12, 1892	
9 AGE (In years last birthday) 74 yrs		IF UNDER 1 YEAR Months 0 Days 0		IF UNDER 24 HRS Hours 0 Min 0			
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lawyer				10b KIND OF BUSINESS OR IND. STRY Self Employed		11 BIRTHPLACE (State or foreign country) Mill Creek, Penna.	
12 CITIZEN OF WHAT COUNTRY? USA							
13 FATHER'S NAME Landon C. Heskett				14 MOTHER'S MAIDEN NAME Clara Mae			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) (If yes give war or dates of service) yes War I				16 SOCIAL SECURITY NO 220-07-6740		17 INFORMANT Address Miss Helen Tasker, Cumberland, Md.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Occlusion 4/20/1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Sclerosis DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH Sudden ---	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Benedict Skitarelic M.D. EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.				22. DATE SIGNED DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> May 5, 1967 Address (Street city town or county) Cumberland, Md.			
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF May 8, 1967		23c NAME OF CEMETERY OR CREMATORY Philos Cemetery		23d LOCATION (City or town) (County) (State) Westernport, Md. Allegany	
24 FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.				25a REC'D BY REGISTRAR DATE MAY 11 1967		25b REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

06023

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06018

1 PLACE OF DEATH a COUNTY Allegany MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a STATE Maryland b COUNTY Allegany	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland Md.		c LENGTH OF STAY IN TB 24 Hours	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital		e STREET ADDRESS 537 Maryland Street	
3 NAME OF DECEASED (Type or print) Herbert First Huston Middle Jewell Last		4 DATE OF DEATH May Month 25 Day Year 1967	
5 SEX M	6 COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 1904 July 22, 1904
9 AGE (In years last birthday) yrs. 62		F UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Boilermaker and		10b. KIND OF BUSINESS OR INDUSTRY Welder, Railroad	
11 BIRTHPLACE (State or foreign country) Strasburg, Va.		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME Toliver Jewell		14 MOTHER'S MAIDEN NAME Mary Ellen Higgs	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16 SOCIAL SECURITY NO	
17 INFORMANT Vera Louise Jewell		Address 537 Maryland St LaVale	
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Coronary Sclerosis with Thrombosis Conditions, if any which gave rise to immediate cause (a) stating the underlying cause last. (b) (c) PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH Hours 11	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (home, farm, factory, street, office, bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL EXAMINER'S SIGNATURE Benedict Skitarelic M.D. NAME (Type) BENEDICT SKITARELIC, M.D.		22. DATE SIGNED May 25, 1967 Address (Street, city, town, or county) Cumberland, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 5-28-67	23c. NAME OF CEMETERY OR CREMATORY Restlawn Memorial Garden	23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany Md.
24 FUNERAL DIRECTOR James F. Scarpelli		25a. RECD BY REGISTRAR MAY 31 1967	
ADDRESS Cumberland, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any doubt is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Pages 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

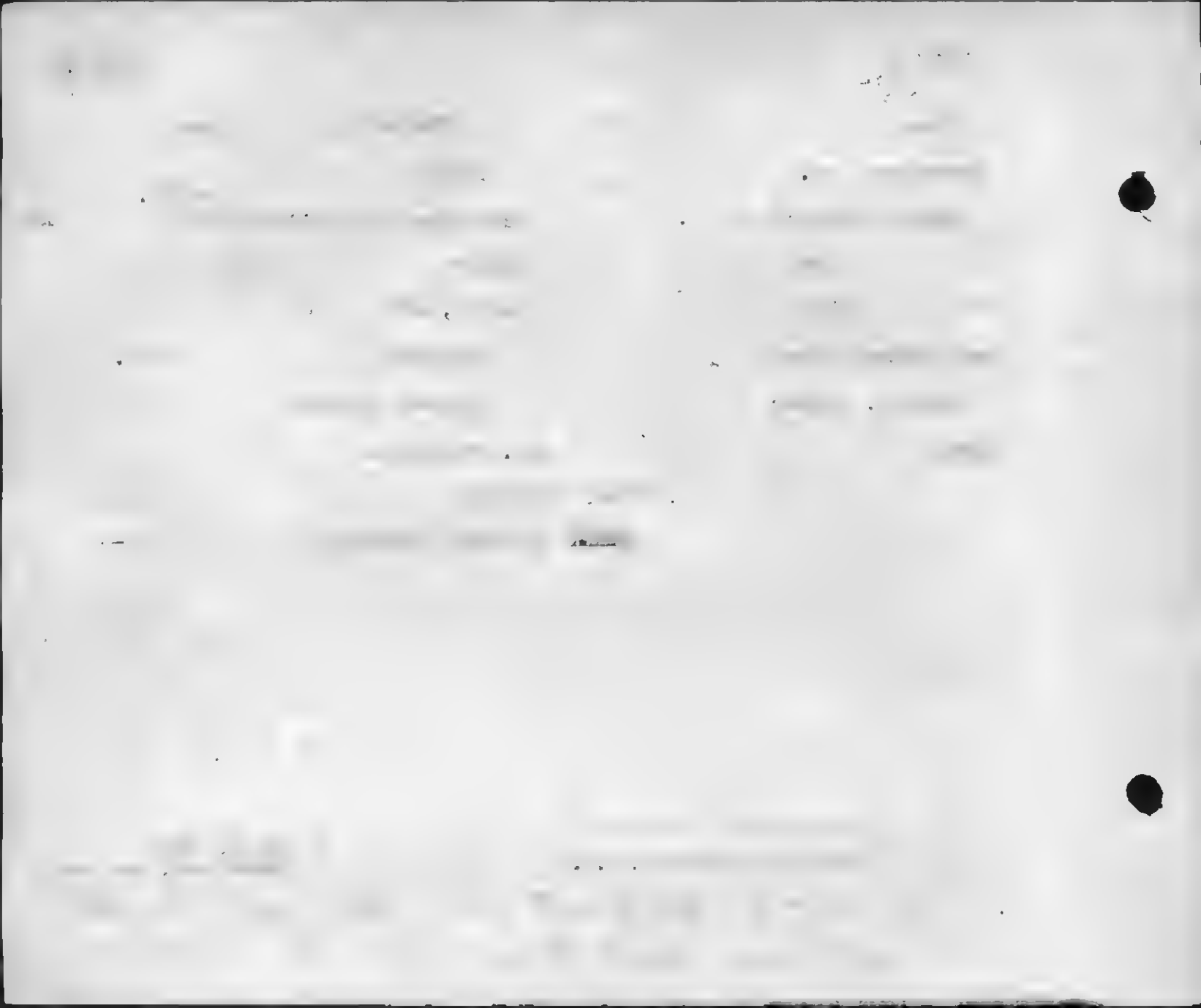
1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06030

06019

1. PLACE OF DEATH a. COUNTY Allegany		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gumbarland Md.		c. LENGTH OF STAY IN 1b MARYLAND	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Memorial Hospital D O A.		e. STATE New York		f. COUNTY Westchester	
g. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) New York		h. STREET ADDRESS 8100 Shore Front Parkway		i. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
j. DATE OF DEATH May 11 1967		k. AGE (In years last birthday) 69		l. IF UNDER 1 YEAR Months Days 11	
m. IF UNDER 24 HRS. Hours Min. 19		n. CITIZEN OF WHAT COUNTRY? U S A.		o. BIRTHPLACE (State or foreign country) Lithuania	
p. MOTHER'S MAIDEN NAME Miriam Friedland		q. SOCIAL SECURITY NO. 070-28-2494		r. INFORMANT Mrs. Ben Kantner	
s. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Unknown		t. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION DUE TO Conditions, if any, which gave rise to immediate cause (b) CORONARY SCLEROSIS (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH SUDDEN	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Benedict Skitarelic		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED May 11, 1967	
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county) Cumberland, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/14/67		22c. NAME OF CEMETERY OR CREMATORY St. Ann's Cem.	
22d. LOCATION (City, town, or country) Farmington Long Island		22e. REG'D BY REGISTRAR MAY 12 1967		22f. REGISTRAR'S SIGNATURE Charles Judge	
23. FUNERAL DIRECTOR James Stein Inc.		ADDRESS Cumbl. Md			



FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

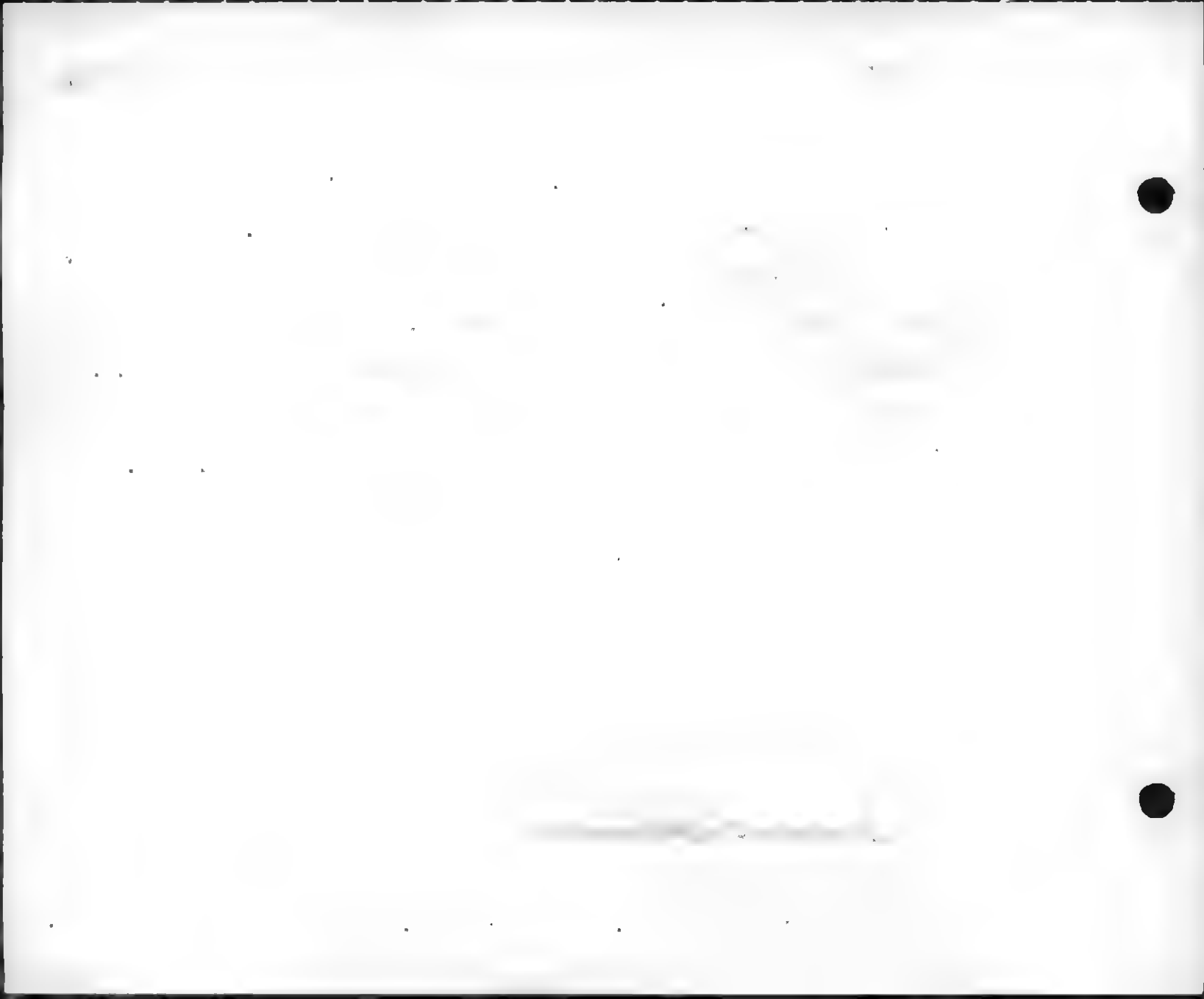
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06031

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06020

1 PLACE OF DEATH a. COUNTY Allegany MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE Maryland b COUNTY Allegany		
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c LENGTH OF STAY IN 1b 50 yrs.		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Hospital			d STREET ADDRESS 806 Columbia Ave.		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) First Middle Last Gladys M Kegg			4 DATE OF DEATH Month Day Year May 15 1967		
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Dec. 15, 1914	9 AGE (In years last birthday) 52 yrs	IF UNDER 1 YEAR Months Days Hours Min 19 67
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) Cumberland Maryland	
12 CITIZEN OF WHAT COUNTRY? U.S.A.			13 FATHER'S NAME Frank Porter		
14 MOTHER'S MAIDEN NAME Lilly Rice			15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) (If yes give war or dates of service) No		
16 SOCIAL SECURITY NO. 70			17 INFORMANT Edgar Kegg Address 806 Columbia Ave.		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac Tamponade DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Ruptured Posterior Myocardium DUE TO (c) Coronary Thrombosis, Right					INTERVAL BETWEEN ONSET AND DEATH Hours 11
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)			
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Benedict Skitarelic M.D. EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.			22. DATE SIGNED DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> May 15, 1967 Address (Street, city, town, or county) Cumberland, Maryland		
23a BURIAL, CREMATION REMOVAL (Specify) Burial	23b DATE THEREOF May 18, 1967	23c NAME OF CEMETERY OR CREMATORY SS. Peter & Paul Cem.		23d LOCATION (City or Town)	(County) (State) Cumberland Allegany Md.
24 FUNERAL DIRECTOR Louis Stern Inc. Cumb. Md.			25a REC'D BY REGISTRAR MAY 19 1967	25b REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN ID 17 DAYS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SACRED HEART HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND d. STREET ADDRESS 194 CENTER STREET e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First LORETTA Middle M. Last KENNEY		4. DATE OF DEATH Month MAY Day 20 Year 19 67	
5. SEX FEMALE		6. COLOR OR RACE WHITE	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 04-07-88	
9. AGE (In years last birthday) 79 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SEAMRESS (RETIRED)	
11. BIRTHPLACE (County & State, or foreign country) BARTON, ALLEGANY, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JAMES		14. MOTHER'S MAIDEN NAME ANNA (MC GREEVY)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 214-05-4426	
17. INFORMANT PATIENTS HOSP. RECORD		Address SACRED HEART	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular Failure DUE TO (b) Arteriosclerotic Heart Disease DUE TO (c) Chronic Congestive Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Pulmonary Emphysema			INTERVAL BETWEEN ONSET AND DEATH ? ?
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5/3 , 19 67 , to 5/20 , 19 67 , that (I) (we) last saw the deceased alive on 5/19 , 19 67 , and that death occurred at 6:15 AM, from the causes and on the date stated above.			
22a. SIGNATURE 		22b. DATE SIGNED 5/20/67	
22c. PHYSICIAN'S NAME (Type) DR. PAGAN		22d. ADDRESS 5 POTOMAC STREET, RIDGELEY, W. VA.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/23/67	
23c. NAME OF CEMETERY OR CREMATORY St. Patrick's Cdn		23d. LOCATION (City, town or county) (State) Cumberland Md.	
24. FUNERAL DIRECTOR Louis Stein Inc. Cumb. Md.		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE MAY 23 1967	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

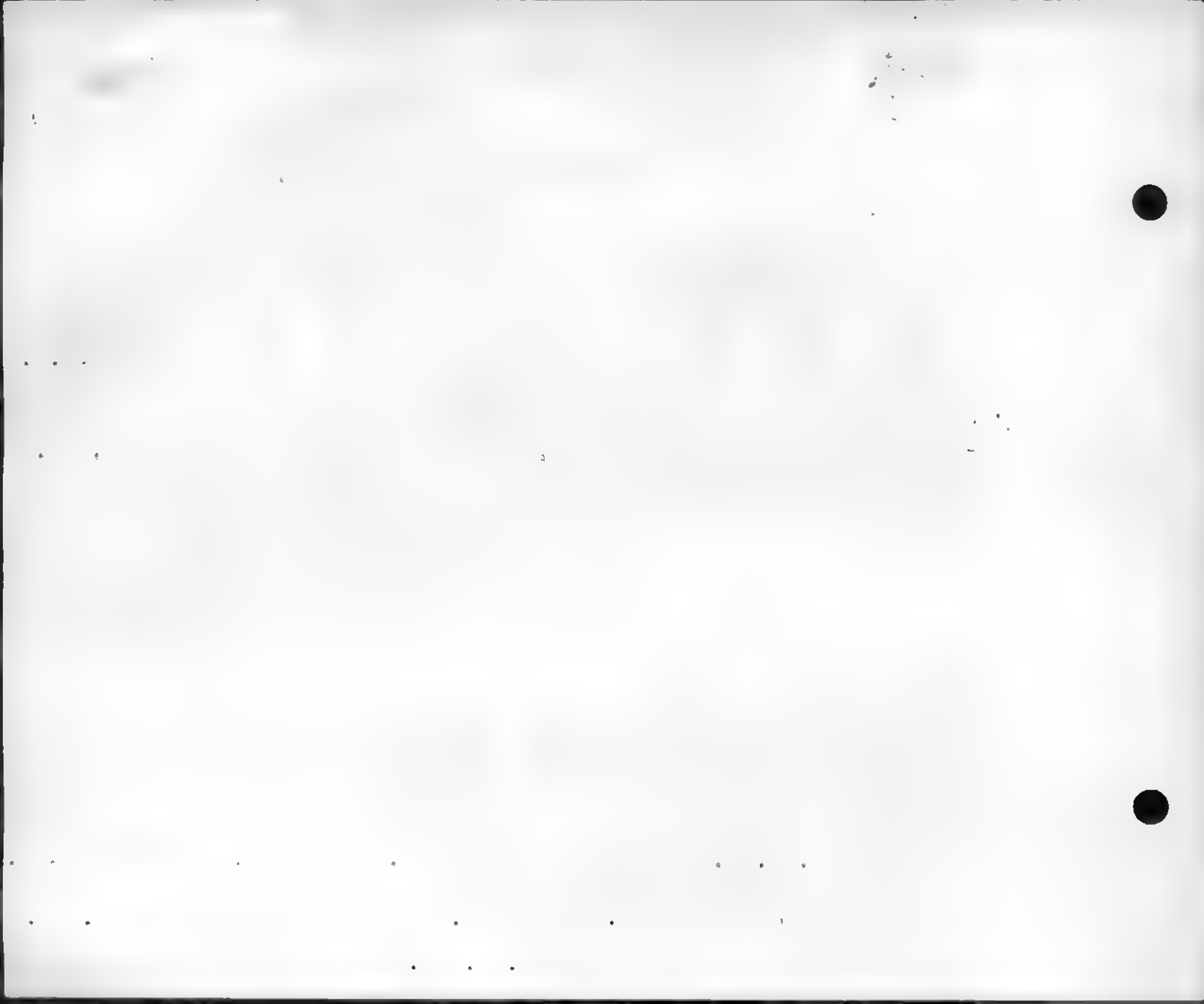
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06035

CERTIFICATE OF DEATH

06022

1 PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE WEST VIRGINIA b. COUNTY BERKLEY ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN IT 15 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		e. STREET ADDRESS PAW PAW, W. VA.	
3 NAME OF DECEASED (Type or print) First FLOYD Middle L Last KIFER		4 DATE OF DEATH Month MAY Day 10 Year 19 67	
5 SEX MALE	6 COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 9-23-89
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) KIPER, MD.
13. FATHER'S NAME DAVID KIFER		14. MOTHER'S MAIDEN NAME AMANDA ASHKETTLE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 236 20 9355	17. INFORMANT MEMORIAL HOSPITAL Address CUMBERLAND, MD.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Cerebral Hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Hemorrhage DUE TO Cerebral Hemorrhage (c)			INTERVAL BETWEEN ONSET AND DEATH 3 days
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II at item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State) Cumberland City, Md.
21. I certify that (I) (this hospital) attended the deceased from 4/20/67 to 5/10/67 , 19 67 that (I) (we) last saw the deceased alive on 5/10/67 , 19 67 , and that death occurred at 7:00A M, from causes and on the date stated above.			
22a. SIGNATURE DR. R. J. WILLIAMS		22b. DATE SIGNED 5/12/67	
22c. PHYSICIAN'S NAME (Type) DR. R. J. WILLIAMS		22d. ADDRESS 122 S. CENTRE ST., CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5/13/1967	23c. NAME OF CEMETERY OR CREMATORY Mt. Union Cem.	23d. LOCATION (City or Town) (County) (State) Slanesville W. Va.
24. FUNERAL DIRECTOR Johnson Funeral Home		25a. REC'D BY REGISTRAR Charles Judge	25b. REGISTRAR'S SIGNATURE Charles Judge



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06034

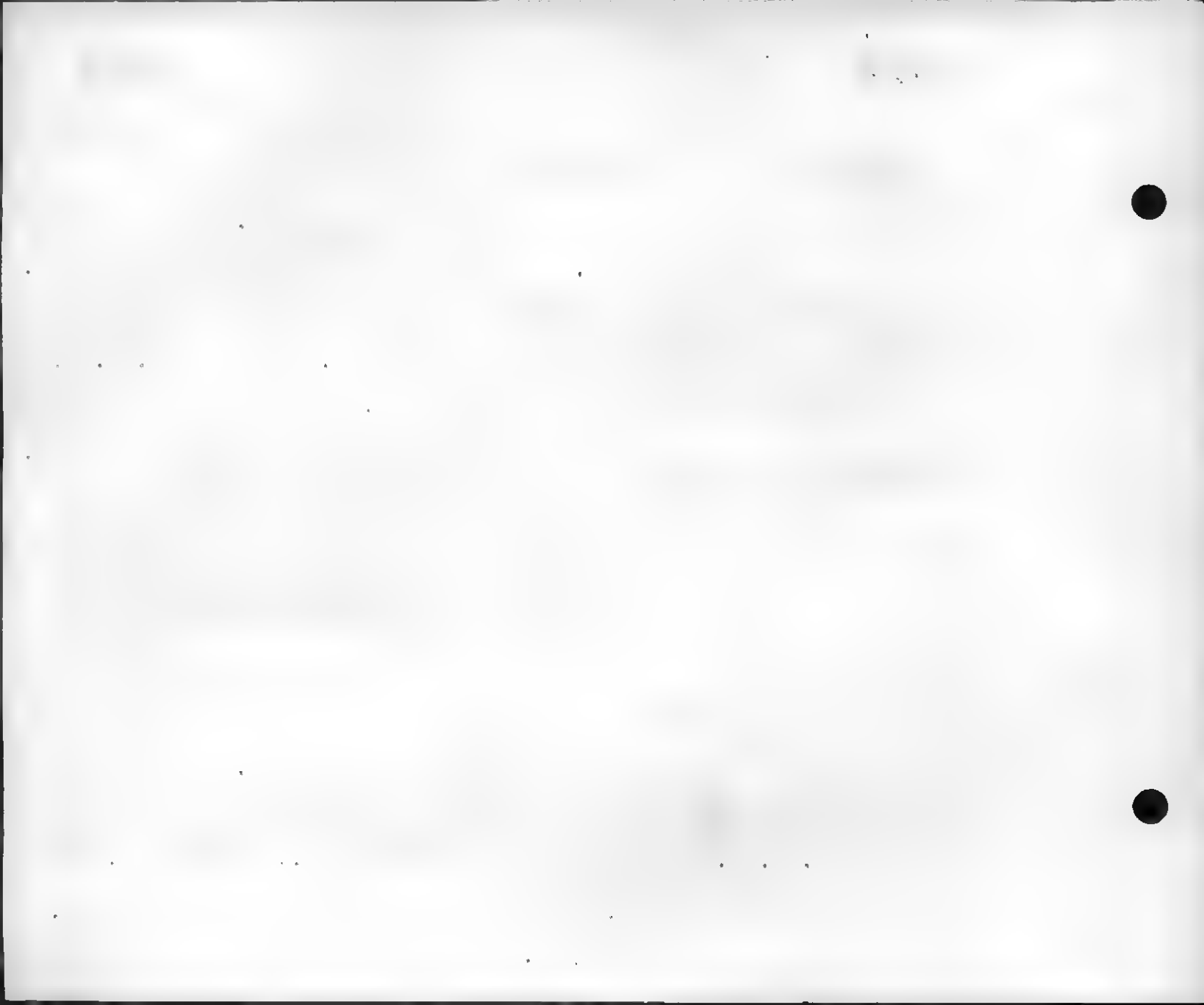
CERTIFICATE OF DEATH

06023

1 PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN IB 24 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		d. STREET ADDRESS 145 BROADWAY ST.,	
3 NAME OF DECEASED (Type or print) First MAUDE Middle C. Last KIRK		4 DATE OF DEATH Month MAY Day 22 , Year 1967	
5 SEX FEMALE	6 COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-27-1890
9 AGE (In years last birthday) yrs 77		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) house wife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) BARTON, MD.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME WILLIAM RUSSELL		14. MOTHER'S MAIDEN NAME JANET C. HERON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO.	
17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA DUE TO (b) NEPHROSCLEROSIS Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last ARTERIOSCLEROSIS + HYPERTENSION DUE TO (c) ARTERIOSCLEROSIS + HYPERTENSION		INTERVAL BETWEEN ONSET AND DEATH 3 days 10 yrs	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4/28 67 , 19 67 , that (I) (we) last saw the deceased alive on 5/21 1967 , and that death occurred at 9:00 A.M. , from causes and on the date stated above			
22a. SIGNATURE DR. S. G. WEISMAN		22b. DATE SIGNED 5/22/67	
22c. PHYSICIAN'S NAME (Type) DR. S. G. WEISMAN		22d. ADDRESS 59 GREENE ST., CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/25/67	
23c. NAME OF CEMETERY OR CREMATORY Mt. View		23d. LOCATION (City or Town) (County) (State) Moscow Mills Md.	
24. FUNERAL DIRECTOR Westernport, Md.		25a. REC'D BY REGISTRAR MAY 24 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

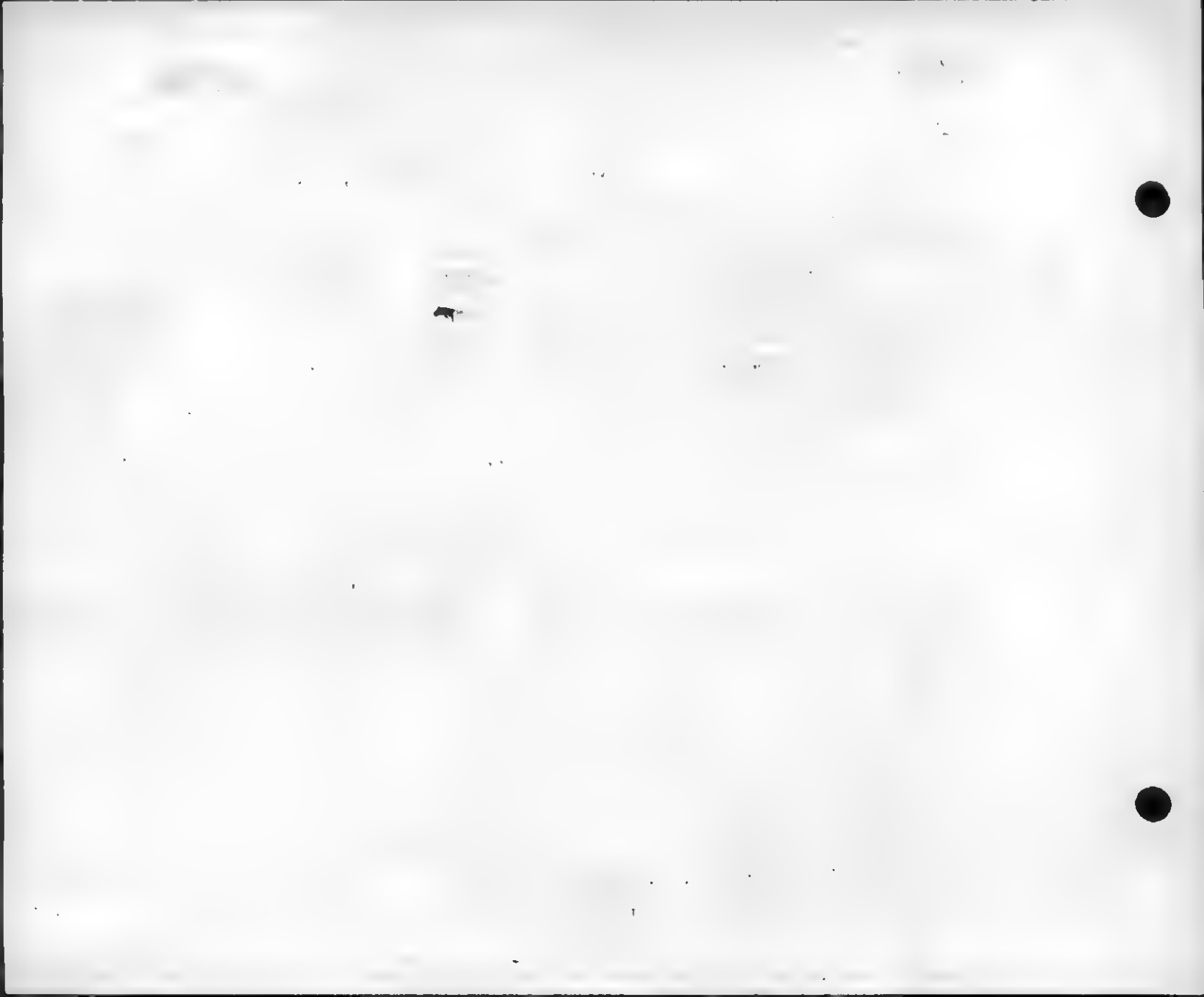
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



12225

256. REGISTRAR'S SIGNATURE
Charles Judge

VR A1 (4)
20 M 1/66



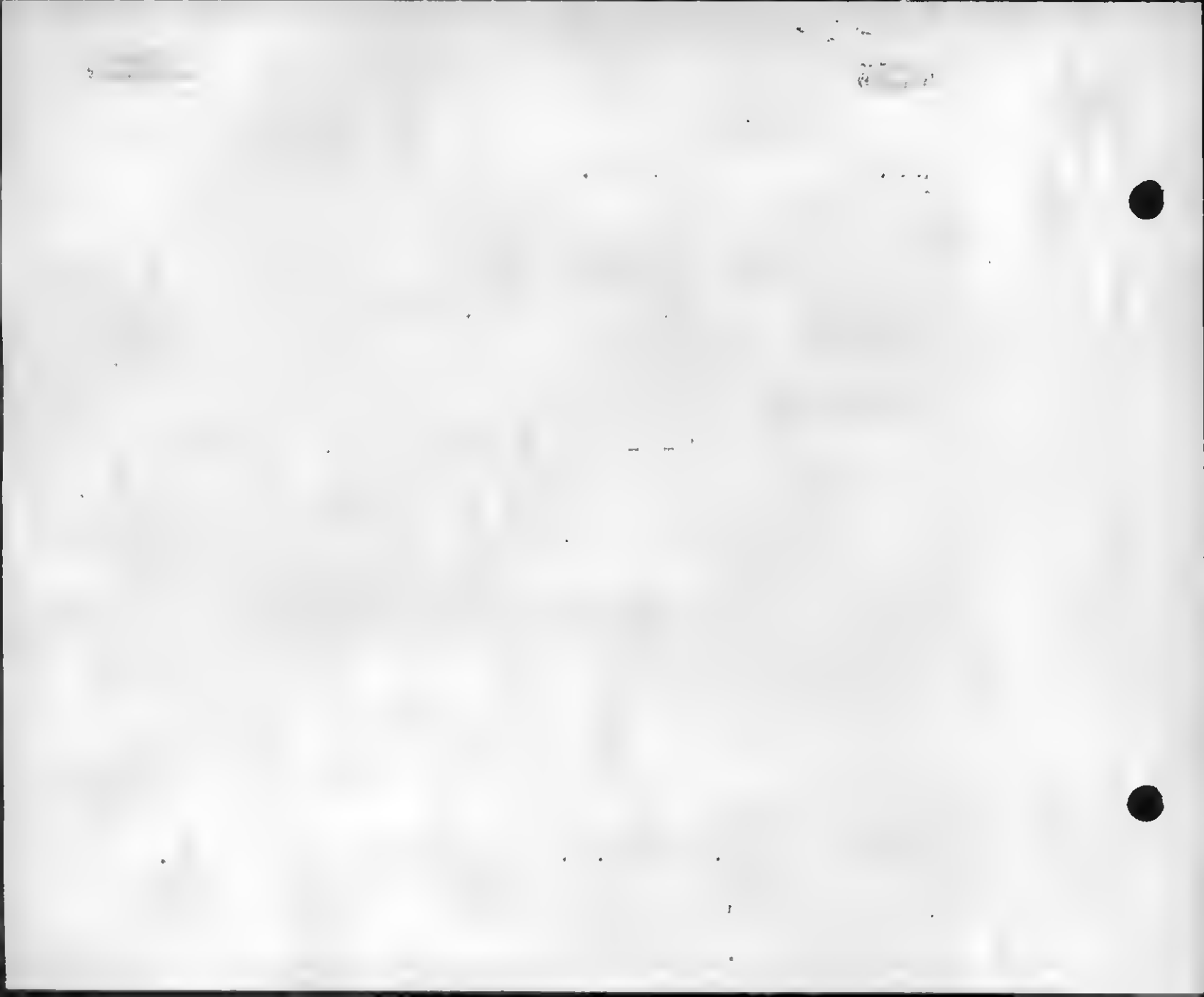
1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06036

06025

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) FROSTBURG				c. LENGTH OF STAY IN ID 14 HRS.			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MINERS HOSPITAL				d. STREET ADDRESS ECKHART			
3. NAME OF DECEASED (Type or print) First ELIZABETH Middle (HARRIS) Last LARGENT				4. DATE OF DEATH Month MAY Day 13 Year 1967			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 14, 1888	9. AGE (in years last birthday) 79 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED COOK		10b. KIND OF BUSINESS OR INDUSTRY RESTAURANT		11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM HARRIS				14. MOTHER'S MAIDEN NAME CATHERINE CROSS			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 212-24-0309		17. INFORMANT Address MRS. BETTY CARTER, ECKHART, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure - Rt side DUE TO ASCVD. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 2 days years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 1967 to May 13, 1967 that (I) (we) last saw the deceased alive on May 13, 1967 and that death occurred at 9:45 M, from the causes and on the date stated above.							
22a. SIGNATURE John B. Davis				22b. DATE SIGNED 5/16/67			
22c. PHYSICIAN'S NAME (Type) JOHN B. DAVIS, M. D.				22d. ADDRESS 2 BROADWAY, FROSTBURG, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF MAY 16 '67		23c. NAME OF CEMETERY OR CREMATORY FBG. MEMORIAL PARK		23d. LOCATION (City, town or county) (State) FROSTBURG, MD.	
24. FUNERAL DIRECTOR JOSEPH R. DURST, SR., FROSTBURG, MD.				25a. REC'D BY REGISTRAR MAY 18 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	



12

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

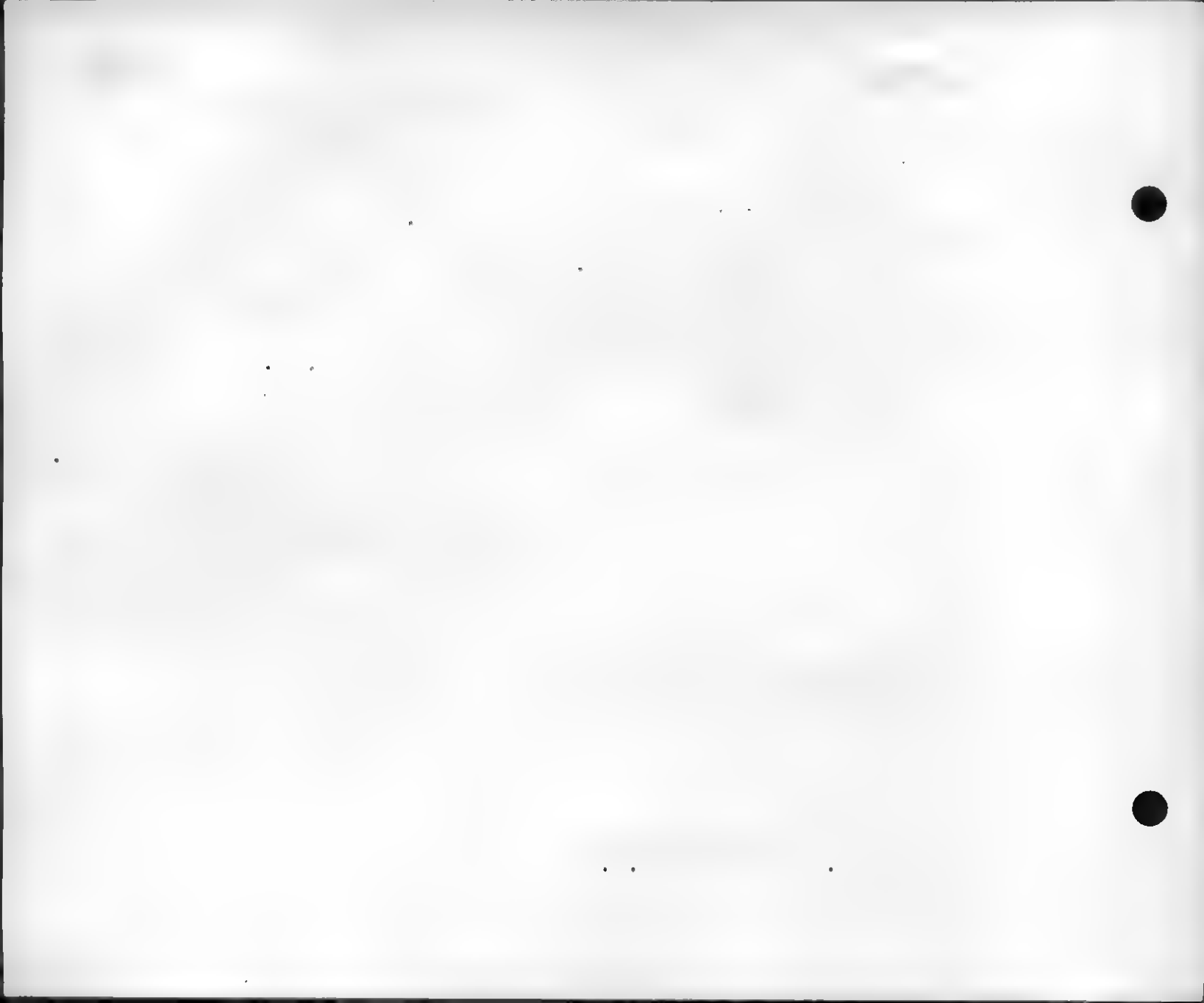
1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08026

1 PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE WEST VIRGINIA b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RIDGELEY	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		d. STREET ADDRESS RT. #1	
3 NAME OF DECEASED (Type or print) First MAXINE Middle L. Last LECHLITER		4 DATE OF DEATH Month MAY Day 5 Year 1967	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-5-1919
9. AGE (In years and birthday) 47 yrs		10. IF UNDER 1 YEAR Months 5 Days 19 Hours 67 Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress		10b. KIND OF BUSINESS OR INDUSTRY Blouse Factory	
11. BIRTHPLACE (County & State, or foreign country) KEYSER, W.VA.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ROBERT SIMPSON		14. MOTHER'S MAIDEN NAME MARY ANDERSON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO.	
17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Natural Hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last Coronary atherosclerosis DUE TO (b) Abdominal DUE TO (c) Cancer of Esophagus Stage IV		INTERVAL BETWEEN ONSET AND DEATH 7 mos	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at 2:26 PM from causes and on the date stated above			
22a. SIGNATURE L. Louis Mould		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) L. LOUIS MOULD M.D.		22d. ADDRESS 1068 NATIONAL HIGHWAY, LA VALE, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF May 8, 1967	23c. NAME OF CEMETERY OR CREMATORY Mt. Zion Cemetery	23d. LOCATION (City or Town) (County) (State) Near Keyser, W.Va.
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		25a. REC'D BY REGISTRAR MAY 17 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

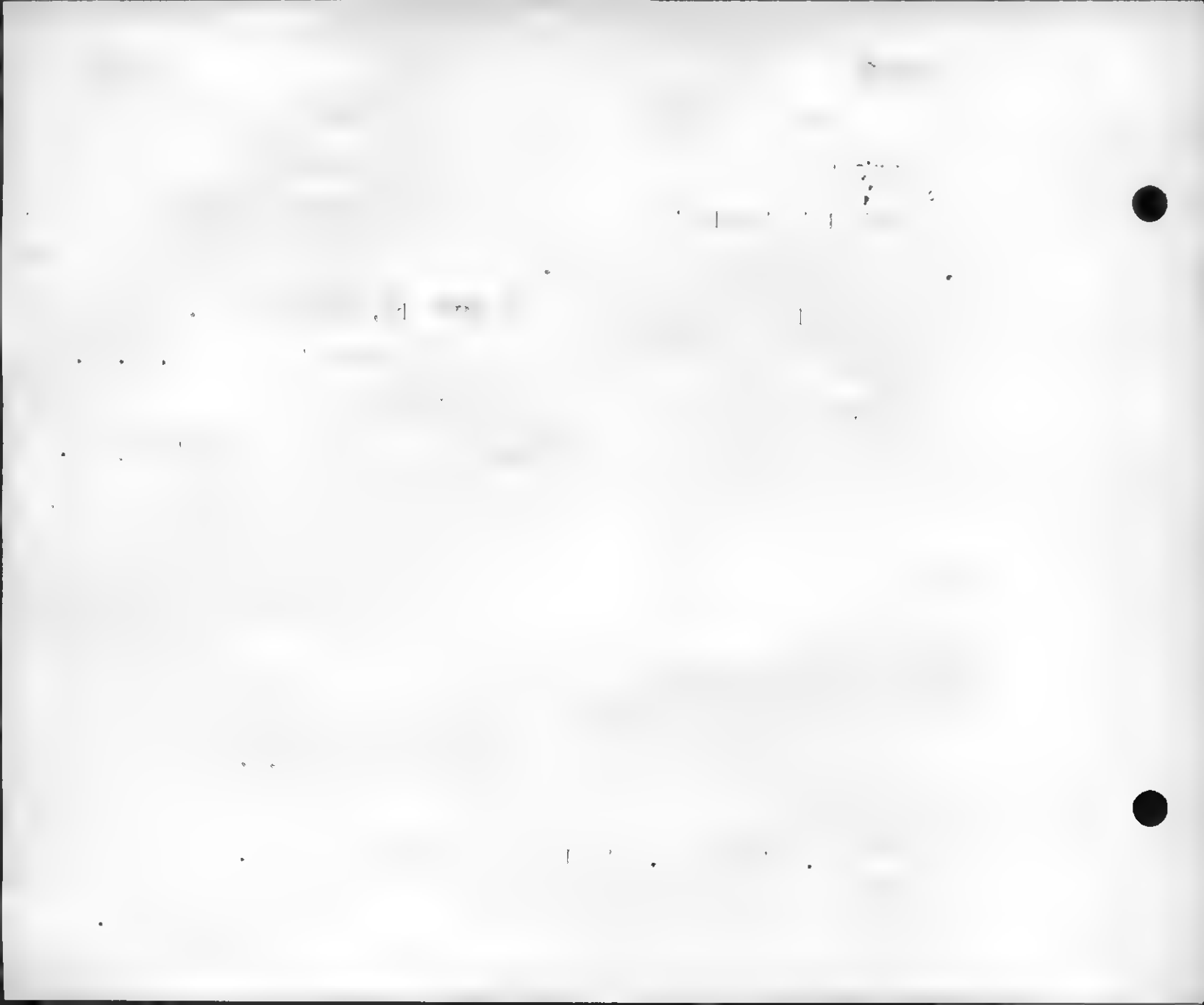
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06038

CERTIFICATE OF DEATH

06027

1. PLACE OF DEATH a COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE MARYLAND b COUNTY ALLEGANY	
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) CUMBERLAND		c LENGTH OF STAY IN 1b 1 DAY	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		d STREET ADDRESS 100 ROBERTS STREET	
3 NAME OF DECEASED (Type or print) First ERNEST Middle L. Last LEE		4. DATE OF DEATH Month MAY Day 5 Year 1967	
5 SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 5-13-1893 AGE (In years, months, days, hours, minutes) MAY 13, 1893-73 YRS.
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (County & State, or foreign country) WEST VIRGINIA
13. FATHER'S NAME WILLIAM LEE		14. MOTHER'S MAIDEN NAME REBECCA SHAHAN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO	17 INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocarditis & Decompensation</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u> <u>5 yrs</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Feb. 10, 1965</u> <u>5:55 A.M.</u> <u>May 5, 1967</u> that (I) (we) last saw the deceased alive on <u>May 5, 1967</u> , and that death occurred at <u>5:13</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Dr. Richard J. Williams</u>		22b DATE SIGNED <u>5/13/67</u>	22c PHYSICIAN'S NAME (Type) DR. RICHARD J. WILLIAMS
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF May 8, 1967	23c NAME OF CEMETERY OR CREMATORY Wotring Chapel
24 FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		23d LOCATION (City or Town) (County) (State) Rowlesburg, W. Va.	25a REC'D BY REGISTRAR MAY 17 1967
		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
06039 05-28
CERTIFICATE OF DEATH

1. PLACE OF DEATH. a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 51 DAYS			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SACRED HEART HOSPITAL				d. STREET ADDRESS 216 SARATOGA ST.			
3. NAME OF DECEASED (Type or print) MARY First Middle Last				4. DATE OF DEATH MAY 19 1967 Month Day Year			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/6/96	
9. AGE (in years last birthday) 70 yrs.		IF UNDER 1 YEAR Months 19 Days 19 Hours 67 Min.		11. BIRTHPLACE (County & State, or foreign country) ALLEGANY, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME JAMES MORGAN				14. MOTHER'S MAIDEN NAME ELLEN TEMPLETON			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT HOSPITAL RECORD		Address SACRED HEART HOSPITAL	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Cheek Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Secondary Radiation Reaction - Cellulitis (c) Fistula buccal due to (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5/29 , 19 67 , to 5/19 , 19 67 , that (I) (we) last saw the deceased alive on 5/19 , 19 67 , and that death occurred at 5:55 M, from the causes and on the date stated above.							
22a. SIGNATURE A. J. Hinkley				22b. DATE SIGNED 5/21/67		22c. PHYSICIAN'S NAME (Type) A. J. Hinkley	
22d. ADDRESS		22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 5/23/67		23c. NAME OF CEMETERY OR CREMATORY St. Patrick's Cem.		23d. LOCATION (City, town or county) (State) Cumberland MD	
24. FUNERAL DIRECTOR Louis Stein Inc.		ADDRESS Cumb. MD		25a. REC'D BY REGISTRAR MAY 23 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

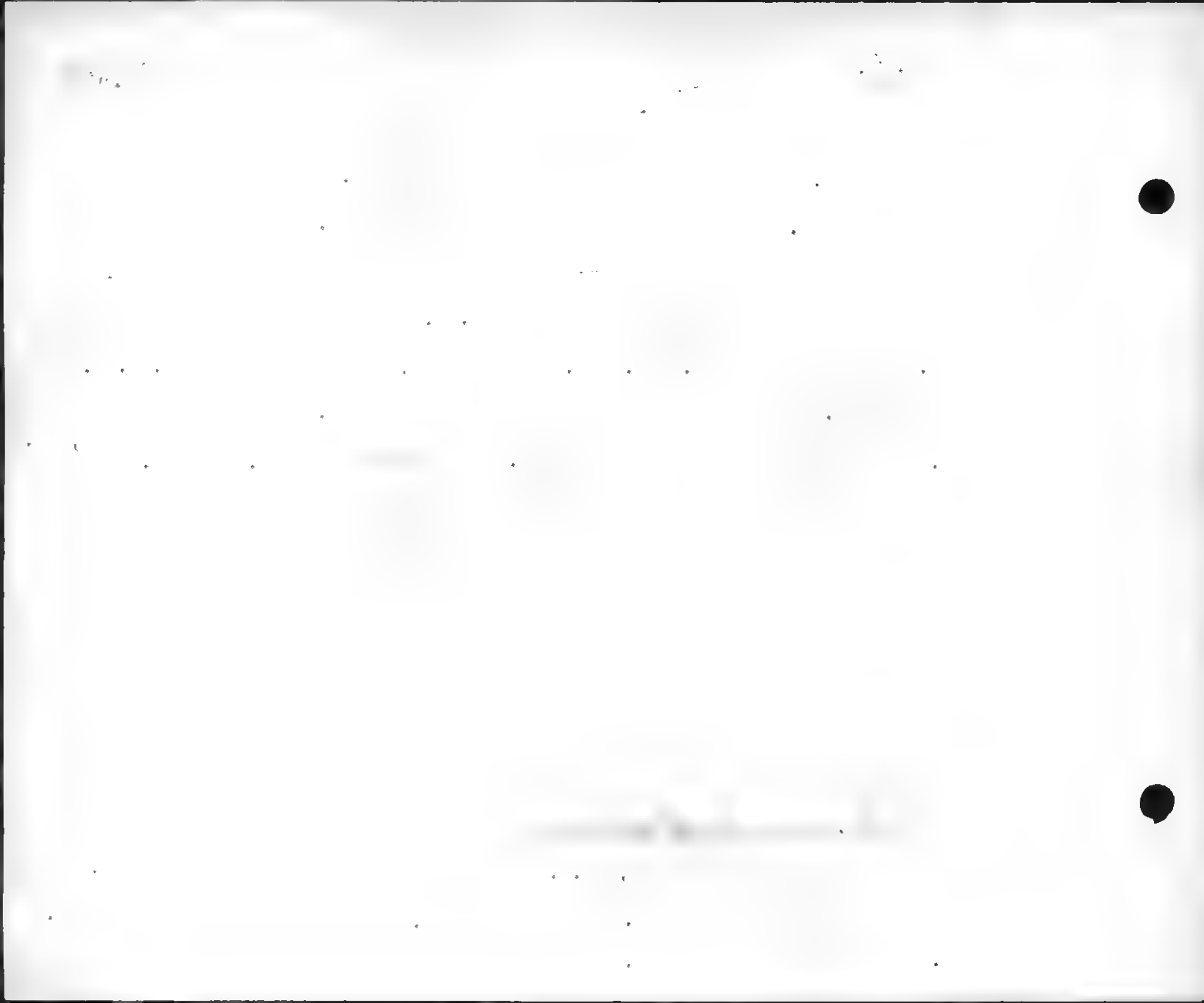
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06040

06029

1 PLACE OF DEATH a COUNTY Allegany MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a STATE Maryland b COUNTY Allegany	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland,		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland,	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 81 Greene St.		d STREET ADDRESS 81 Greene St.	
3 NAME OF DECEASED (Type or print) First Middle Last Blanche --- Lippold		4 DATE OF DEATH Month Day Year May 7, 1967	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Oct. 9, 1898
9 AGE (In years last birthday) 68		10 IF UNDER 1 YEAR Months Days Hours Min 0 0 0 0	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. clerk		10b KIND OF BUSINESS OR INDUSTRY B. & O. Rwy.	
11 BIRTHPLACE (State or foreign country) Barton, Maryland		12 COUNTRY OF WHAT COUNTRY? U. S. A.	
13 FATHER'S NAME William H. Thomas		14 MOTHER'S MAIDEN NAME Elizabeth P. Turnbull	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No,		16 SOCIAL SECURITY NO	
17 INFORMANT Mr. George Thomas		Address Arlington, Va. 4126 N. 26th Rd. 22207	
B CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CORONARY OCCLUSION DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) CORONARY SCLEROSIS DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH SODDEN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office, bag, etc.)		20f (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Benedict Skitarelic M.D.		22. DATE SIGNED May 7, 1967	
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) Cumberland, Maryland	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF 5/11/67	23c NAME OF CEMETERY OR CREMATORY SS. Peter & Paul Cem.	23d LOCATION (City or Town) (County) (State) Cumberland, Allegany Md.
24 FUNERAL DIRECTOR H. Wayne George		25a REC'D BY REGISTRAR MAY 11 1967	
ADDRESS Cumberland, Maryland		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1-67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06041

CERTIFICATE OF DEATH

06030

1 PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) o STATE MARYLAND b COUNTY ALLEGANY				
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			c LENGTH OF STAY in 1b 31 DAYS			c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL				d STREET ADDRESS 468 BALTIMORE AVENUE		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3 NAME OF DECEASED (Type or print) First MARGARET Middle A. Last LITTEN				4 DATE DEATH MAY 19 67				
5 SEX FEMALE		6 COLOR OR RACE WHITE		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH 6-14-92		
9 AGE (n years last birthday) 74 yrs		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS Hours Min				
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) MARYLAND-CUMBERLAND		12 CITIZEN OF WHAT COUNTRY U. S. A.	
13 FATHER'S NAME MOONEY, ANDREW J.				14. MOTHER'S MAIDEN NAME DIGAN, JOHANNA M.				
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no			16 SOCIAL SECURITY NO 215-16-4492		17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the ovary with metastases to liver, colon, lymph nodes 1750 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Lymph nodes DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 1 year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1967 3:00 P.M. 5/2/67 , that (I) (we) last saw the deceased alive on 5/19/67 , and that death occurred at 5/19/67 M, from causes and on the date stated above.								
22a. SIGNATURE DR. S. G. WEISMAN M.D.				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b DATE SIGNED 5/5/67		
22c PHYSICIAN'S NAME (Type) DR. S. G. WEISMAN				22d ADDRESS CUMBERLAND, MD.				
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF May 5, 1967		23c NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		23d LOCATION (City or Town) (County) (State) Cumberland, Md. Allegany		
24 FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.				25a REC'D BY REGISTRAR MAY 11 1967		25b REGISTRAR'S SIGNATURE Charles J. Jones		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

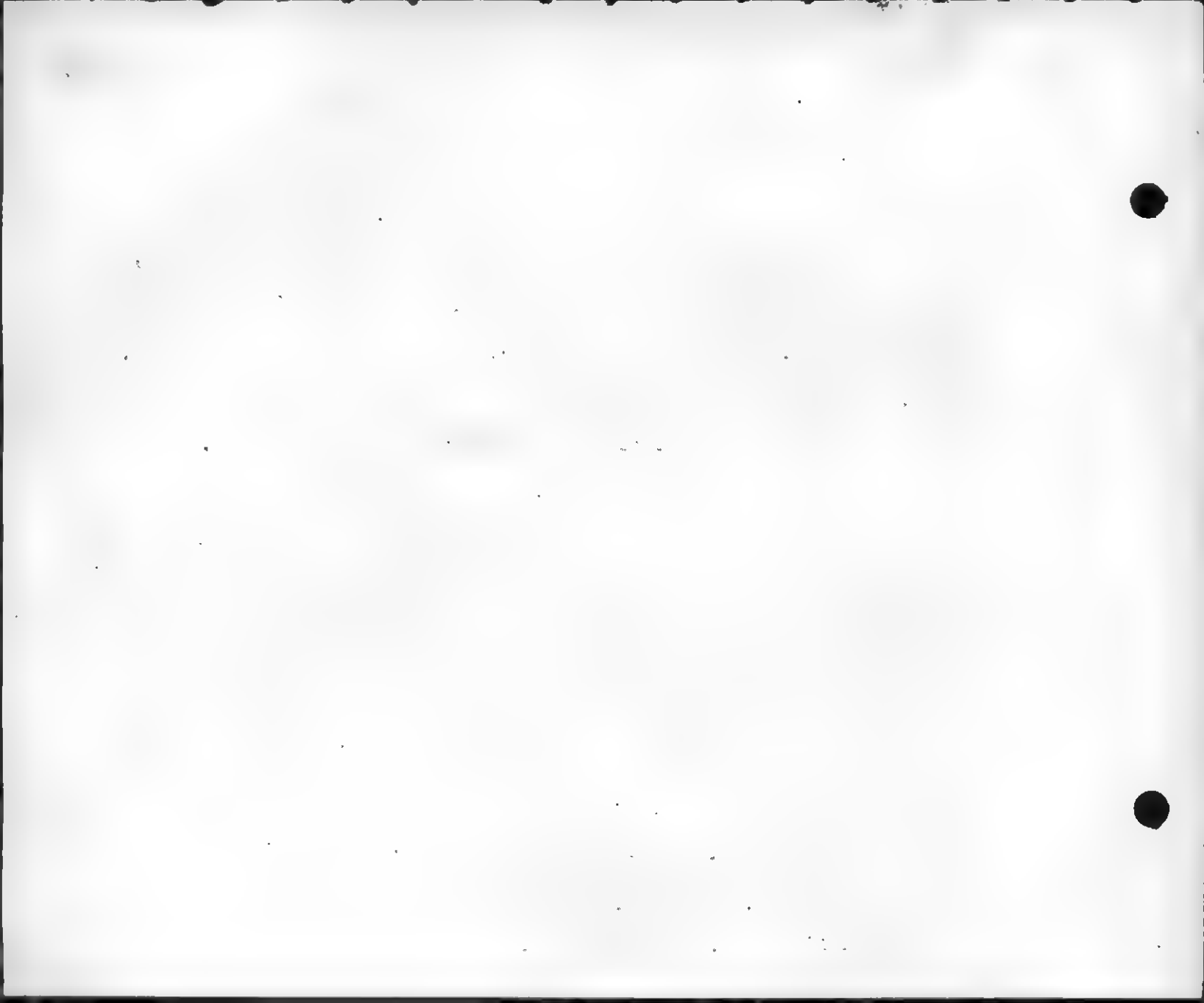
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG		c. LENGTH OF STAY IN 1b 3 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MINERS HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) THOMAS PRICE LLEWELLYN		4. DATE OF DEATH Month MAY Day 21 Year 1967	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN. 7, 1891
9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SUPERVISOR OF MAIN.		10b. KIND OF BUSINESS OR INDUSTRY REFRACOTORIES	
11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME PHILLIP LLEWELLYN		14. MOTHER'S MAIDEN NAME MARGARET PRICE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) 12-10-6300A		17. INFORMANT MRS. BEULAH LLEWELLYN, FROSTBURG, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) GENERALIZED ANASARCA DUE TO (b) PRIMARY ANEMIA DUE TO (c) 6 months		INTERVAL BETWEEN ONSET AND DEATH 6 months	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <input type="checkbox"/> p.m. <input type="checkbox"/> 19 <input type="checkbox"/>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 5/18/1967 to 5/21/1967 , that (I) (we) last saw the deceased alive on 5/21/1967 , and that death occurred at 9:45 A.M. , from causes on and on the date stated above.			
22a. SIGNATURE G. Paige Strong		22b. DATE SIGNED 5/21/67	
22c. PHYSICIAN'S NAME (Type) A. PAIGE STRONG		22d. ADDRESS 167 E. MAIN ST. - FROSTBURG, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF MAY 24 1967	23c. NAME OF CEMETERY OR CREMATORY F.B.G. MEMORIAL PARK	23d. LOCATION (City or Town) (County) (State) FROSTBURG, MD.
24. FUNERAL DIRECTOR JOSEPH R. DURST, SR., FROSTBURG, MD.		25a. REC'D BY REGISTRAR MAY 25 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
06043 CERTIFICATE OF DEATH 00032									
1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 48 MILL STREET					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG d. STREET ADDRESS 48 MILL STREET e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First HENRY Middle F. Last LLOYD					4. DATE OF DEATH Month MAY Day 10 Year 1967				
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH OCT. 12, 1901		9. AGE (In years last birthday) 65 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED ENGINEER. DEPT. CELANESE CORPORATION				10b. KIND OF BUSINESS OR INDUSTRY MARYLAND		11. BIRTHPLACE (County & State, or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WM. H. LLOYD					14. MOTHER'S MAIDEN NAME MARGARET PATTERSON				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES (If yes give war or dates of service) WW1					16. SOCIAL SECURITY NO. 214-07-6607A		17. INFORMANT HENRY LLOYD, FROSTBURG, MD. Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart failure DUE TO (b) Severe Bronchial asthmatic DUE TO (c) CVD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									INTERVAL BETWEEN ONSET AND DEATH 1 day - years - years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 1 , 19 62 to May 10 , 19 65 , that (I) (we) last saw the deceased alive on 5/10 , 19 62 , and that death occurred at 2 PM , from the causes and on the date stated above.									
22a. SIGNATURE John B. Davis, M.D.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 5/12/67		
22c. PHYSICIAN'S NAME (Type) JOHN B. DAVIS, M. D.					22d. ADDRESS 2 BROADWAY, FROSTBURG, MD.				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE THEREOF MAY 13, 1967		23c. NAME OF CEMETERY OR CREMATORY FBG. MEMORIAL PARK		23d. LOCATION (City, town or county) (State) FROSTBURG, MD.		
24. FUNERAL DIRECTOR JOSEPH R. DURST, SR., FROSTBURG, MD.					25a. REC'D BY REGISTRAR MAY 15 1967		25b. REGISTRAR'S SIGNATURE Charles Judge		



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06044

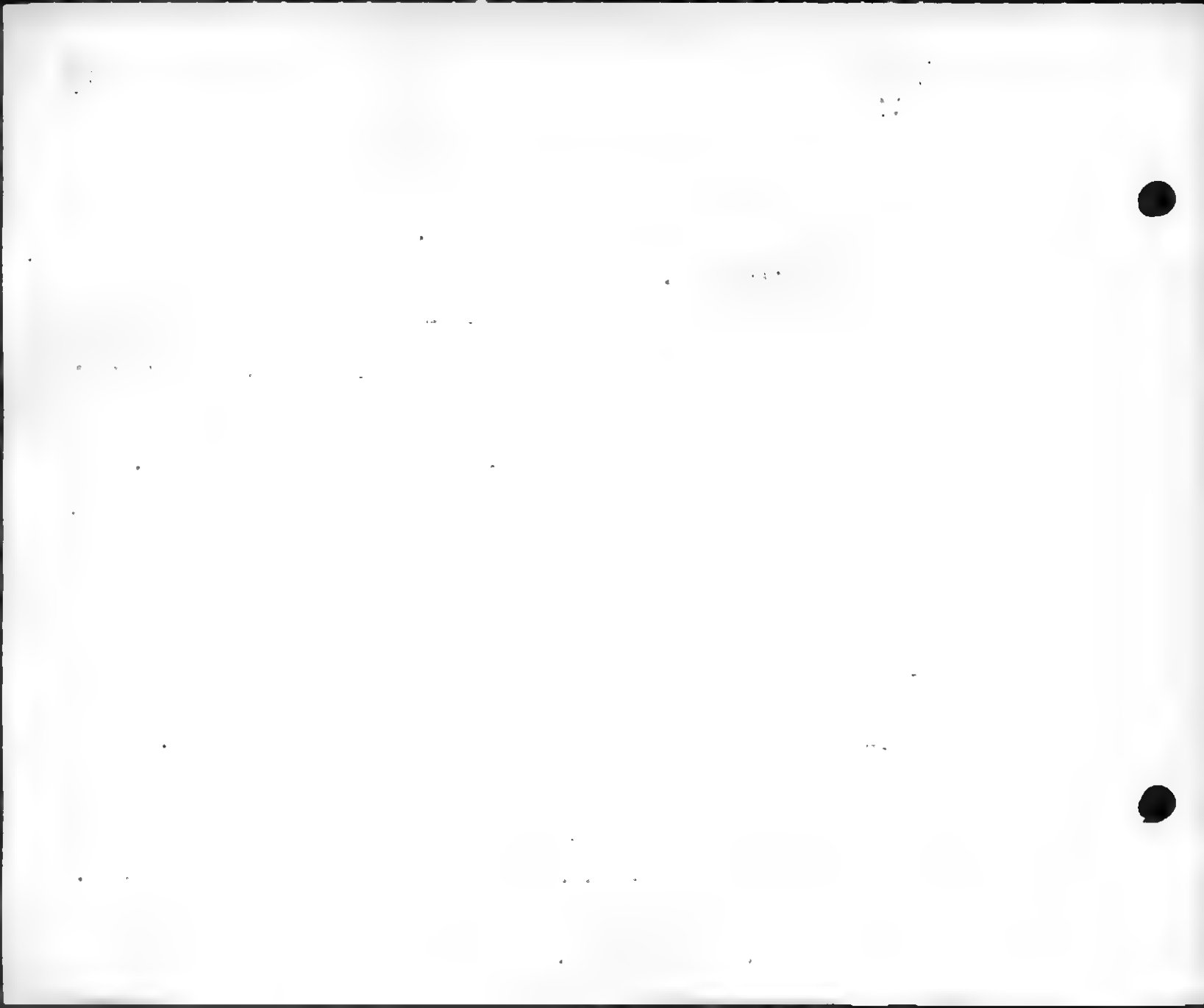
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

35033

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Allegany Frostburg MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN b 2 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Miners Hospital			d. STREET ADDRESS 308 E. Main		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) First Middle Last Burman T. Loar			4 DATE OF DEATH Month Day Year May 12 19 67		
5 SEX M	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 12-30-80		9 AGE (In years last birthday) yrs 86
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired blacksmith		10b. KIND OF BUSINESS OR INDUSTRY Coal mines		11 BIRTHPLACE (State or foreign country) Loar Town, Maryland	
13 FATHER'S NAME Jacob Loar			12 CITIZEN OF WHAT COUNTRY? U. S. A.		
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16 SOCIAL SECURITY NO 216-03-4732A		17. INFORMANT Address Mrs. Novella Crowe, Frostburg, Md.
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Contusions of Brain DUE TO (b) (Fall at Home) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.					INTERVAL BETWEEN ONSET AND DEATH 3 Days
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) Fell at Home			
20c. TIME OF INJURY Month Day Year Hour a.m. 9:00 a.m. May 9 19 67		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) Home	
		20f. (City or town) (County) (State) Frostburg, Alleg. Maryland			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Benedict Skitarelic		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED May 12, 1967	
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county) Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 15 '67		23c. NAME OF CEMETERY OR CREMATORY Frostburg Memorial Park	
				23d. LOCATION (City or Town) (County) (State) Frostburg, Md.	
24 FUNERAL DIRECTOR Joseph R. Durst, Sr., Frostburg, Md.			25a. REC'D BY REGISTRAR MAY 17 1967		25b. REGISTRAR'S SIGNATURE Charles Judge



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

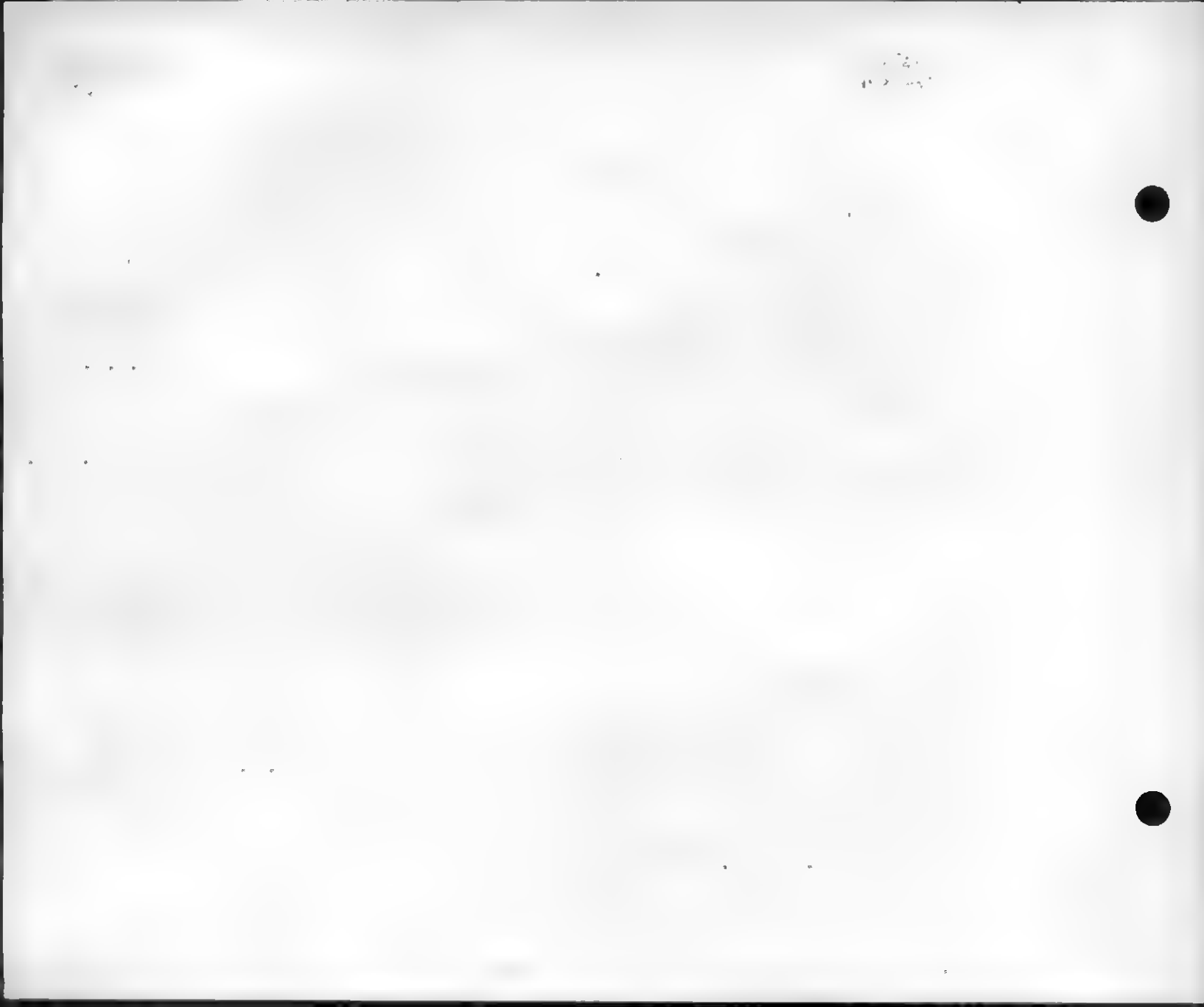
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06045

CERTIFICATE OF DEATH

05024

1 PLACE OF DEATH a COUNTY ALLEGANY MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE WEST VIRGINIA b. COUNTY PATTERSON CREEK	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 22 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First PARKER Middle P. Last LOGSDON		4 DATE OF DEATH Month MAY Day 1 Year 67	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-12-1895
9. AGE (In years last birthday) 72 yrs		10. IF UNDER 1 YEAR Months 20 Days 48 Hours 48 Min 48	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired B & O Signalman		10b. KIND OF BUSINESS OR INDUSTRY West Virginia	
11. BIRTHPLACE (County & State, or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME LOGSDON, GEORGE		14. MOTHER'S MAIDEN NAME ALCARR, MARGARET	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 705-05-1818	
17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolism, Obstructive DUE TO Acute Thrombotic Phlebitis L. L. leg Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) 48 hours (c) Carcinoma Rt. Lung with generalized metastases 8 months		INTERVAL BETWEEN ONSET AND DEATH 20 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) 1 May 1967	
21. I certify that (I) (this hospital) attended the deceased from 1 July 66, 195:25 P.M. , that (I) (we) last saw the deceased alive on 1 May 1967 , and that death occurred at 5:25 P.M. from causes and on the date stated above.			
22a. SIGNATURE W. Alfred Van Ormer		22b. DATE SIGNED 1 May 67	
22c. PHYSICIAN'S NAME (Type) DR. W. A. VAN ORMER		22d. ADDRESS CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/4/67	
23c. NAME OF CEMETERY OR CREMATORY Fort Ashby Cemetery		23d. LOCATION (City or Town) (County) (State) Fort Ashby Mineral W. Va	
24. FUNERAL DIRECTOR H. Lee Silcox 404 Decatur St., Cumberland, Md		25a. RECEIVED BY REGISTRAR MAY 4 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06046

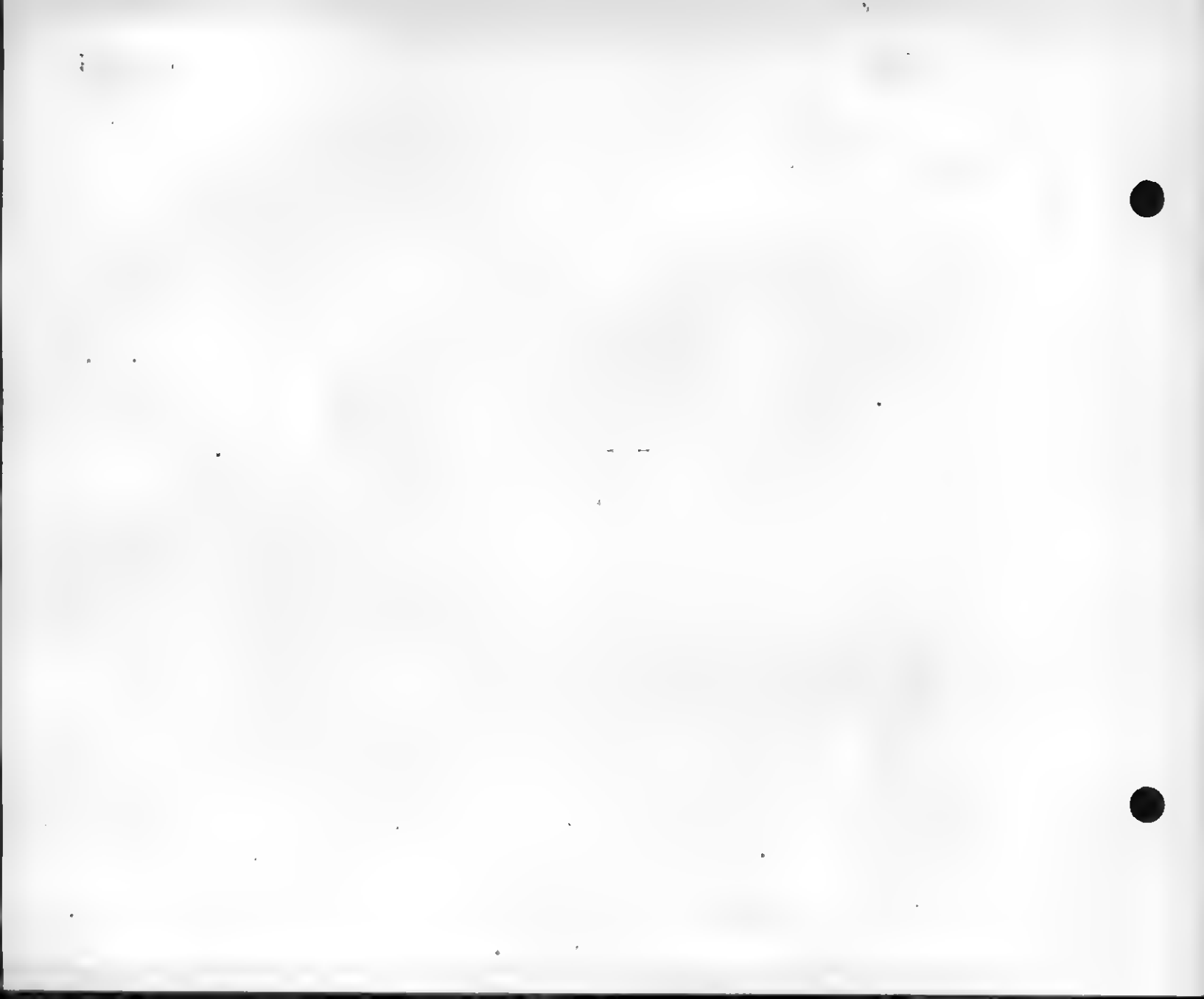
CERTIFICATE OF DEATH

06035

1 PLACE OF DEATH a. COUNTY Allegany MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Westernport		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Westernport	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3 NAME OF DECEASED (Type or print) First John Middle Samuel Last Machin		4. DATE OF DEATH Month May Day 24 Year 19 67	
5 SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 29, 1886
9 AGE (n years last birthday) 80 yrs		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Miner		10b. KIND OF BUSINESS OR INDUSTRY Coal Mine	
11 BIRTHPLACE (County & State, or foreign country) Garrett-Md		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John T. Machin		14. MOTHER'S MAIDEN NAME Emma Handley	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16 SOCIAL SECURITY NO 216-07-7244	
17 INFORMANT Emma Stemp-Cumberland, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4222 IMMEDIATE CAUSE (a) Chronic Myocarditis DUE TO (b) Chronic Bronchitis with Asthma DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH 5 Years 20 Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS A TOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from March 10, 1965 , to May 24, 1967 , that (I) (we) last saw the deceased alive on May 23, 1967 , and that death occurred at 7:45 AM , from causes and on the date stated above.			
22a. SIGNATURE Paul R. Wilson		22b. DATE SIGNED May 24, 1967	
22c. PHYSICIAN'S NAME (Type) Paul R. Wilson		22d. ADDRESS Piedmont, W. Va.	
23a B. RIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF May 26, 1967	23c. NAME OF CEMETERY OR CREMATORY Philos	23d. LOCATION (City or Town) (County) (State) Westernport Md.
24 FUNERAL DIRECTOR E. J. Bral		25a REC'D BY REGISTRAR DATE MAY 29 1967	
25b REG. STARR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH															
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201															
Item #9 Film #G389 6/2/67															
06047					CERTIFICATE OF DEATH					06036					
1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY in 1b 1MO 7DA d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL					2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND d. STREET ADDRESS 309 DECATUR STREET e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
3. NAME OF DECEASED (Type or print) First HAZEL Middle B. Last MALLOY					4. DATE OF DEATH Month MAY Day 26 Year 1967										
SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-7-1903		9. AGE (In years last birthday) 63 64 yrs.		IF UNDER 1 YEAR Months 6 Days 14 Hours 0 Min. 0		IF UNDER 24 HRS Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY OWN HOME				11. BIRTHPLACE (County & State, or foreign country) PIEDMONT, W. VA.				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME DAVID BRADENBERG						14. MOTHER'S MAIDEN NAME BESSIE RAWLINGS									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO				16. SOCIAL SECURITY NO NONE		17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 174X CARCINOMATOSIS-PRIMARY IN UTERUS DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 YRS										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from 3-5 , 19 64 , to 5-26 , 19 67 , that (I) (we) last saw the deceased alive on 5-26 , 19 67 , and that death occurred at 9:00 PM from causes and on the date stated above.															
22a. SIGNATURE Thomas F. Lusby M.D.						22b. DATE SIGNED 5/27/67		22c. PHYSICIAN'S NAME (Type) THOMAS F. LUSBY, M.D.							
22d. ADDRESS 932 NATIONAL HIGHWAY, CUMBERLAND, MD.															
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE THEREOF MAY 29, 1967		23c. NAME OF CEMETERY OR CREMATORY PHILOS CEMETERY				23d. LOCATION (City or Town) (County) (State) WESTERNPORT, MD.					
24. FUNERAL DIRECTOR BYRON KIGHT						ADDRESS CUMBERLAND, MD.		25a. REC'D BY REGISTRAR JUN 1 1967		25b. REGISTRAR'S SIGNATURE Charles Judge					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

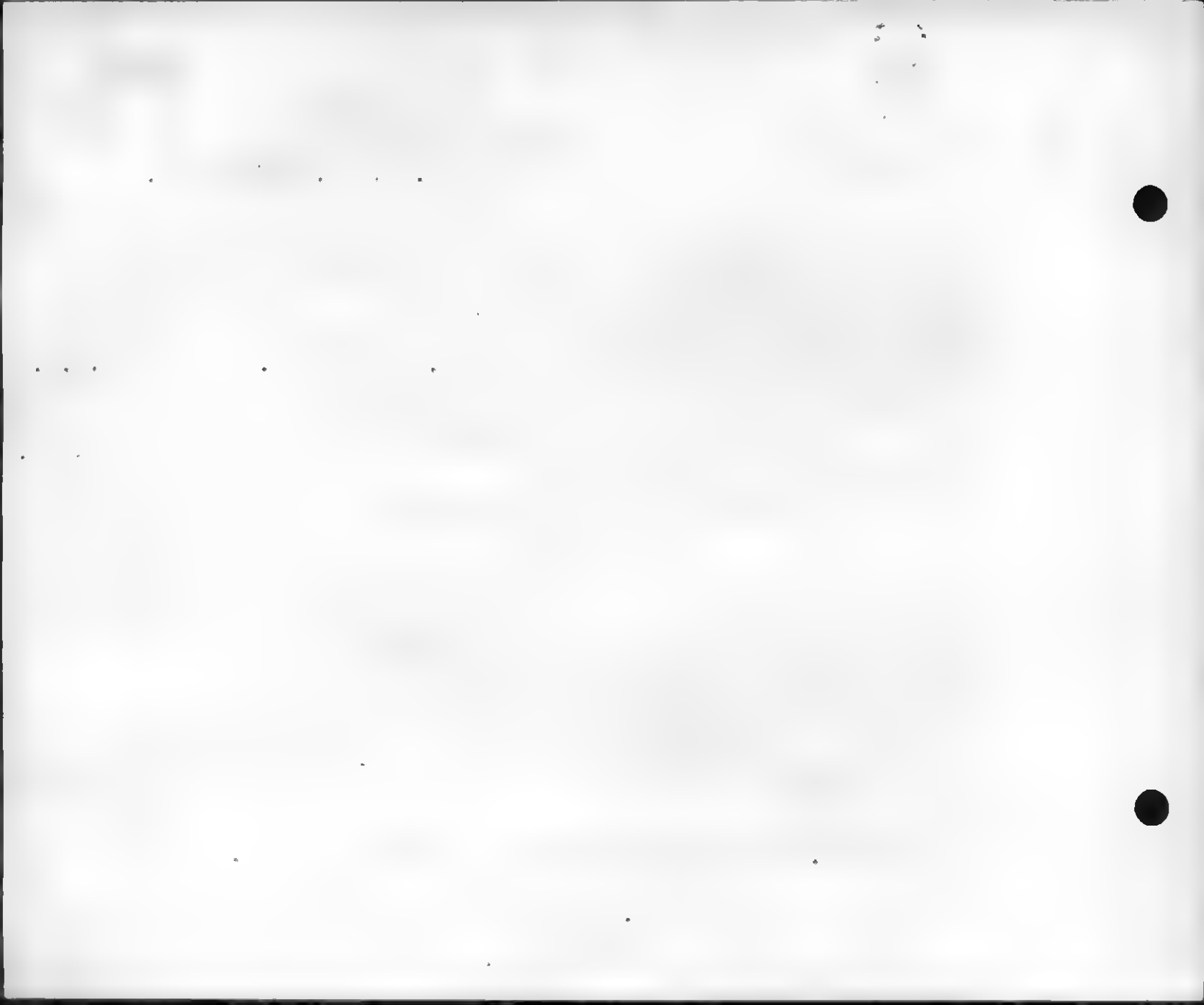
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06048

05037

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 4 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RT. 1, MT. SAVAGE, MD.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOSEPH Middle L Last MALLOY				4. DATE OF DEATH Month MAY Day 11 Year 1967			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-2-02	
9. AGE (in years, lost birthday) 64 yrs.		10. F UNDER 1 YEAR Months _____ Days _____		10. F UNDER 24 HRS Hours _____ Min _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RET. MAINT. MECHANIC				10b. KIND OF BUSINESS OR INDUSTRY CELANESE		11. BIRTHPLACE (County & State, or foreign country) MT. SAVAGE, MD.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME LAWRENCE MALLOY				14. MOTHER'S MAIDEN NAME ANNIE WILLS			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) (If yes give war or dates of service) 214-05-4614				16. SOCIAL SECURITY NO 214-05-4614			
17. INFORMANT MEMORIAL HOSPITAL				Address CUMBERLAND, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebro-Massive Coronary Thrombosis DUE TO Atherosclerotic Cardiovascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Diabetes Mellitus DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH Minutes years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1963 to May 11, 1967 , that (I) (he) last saw the deceased alive on 5/11/67 , and that death occurred at 1:10 P.M. from causes and on the date stated above.							
22a. SIGNATURE DR. OVERTON HIMMELWRIGHT				22b. DATE SIGNED 5/15/67		22c. PHYSICIAN'S NAME (Type) DR. OVERTON HIMMELWRIGHT	
22d. ADDRESS CUMBERLAND, MD.							
23a. BURIAL CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 5-15-67		23c. NAME OF CEMETERY OR CREMATORY ST. PATRICK'S CEMETERY		23d. LOCATION (City or Town) (County) (State) MT. SAVAGE, MD.	
24. FUNERAL DIRECTOR JOSEPH R. DURST, SR.,				ADDRESS FROSTBURG, MD.		25a. REC'D BY REGISTRAR MAY 17 1967	
				25b. REGISTRAR'S SIGNATURE Charles Judge			



FOR STATE
HEALTH DEPT

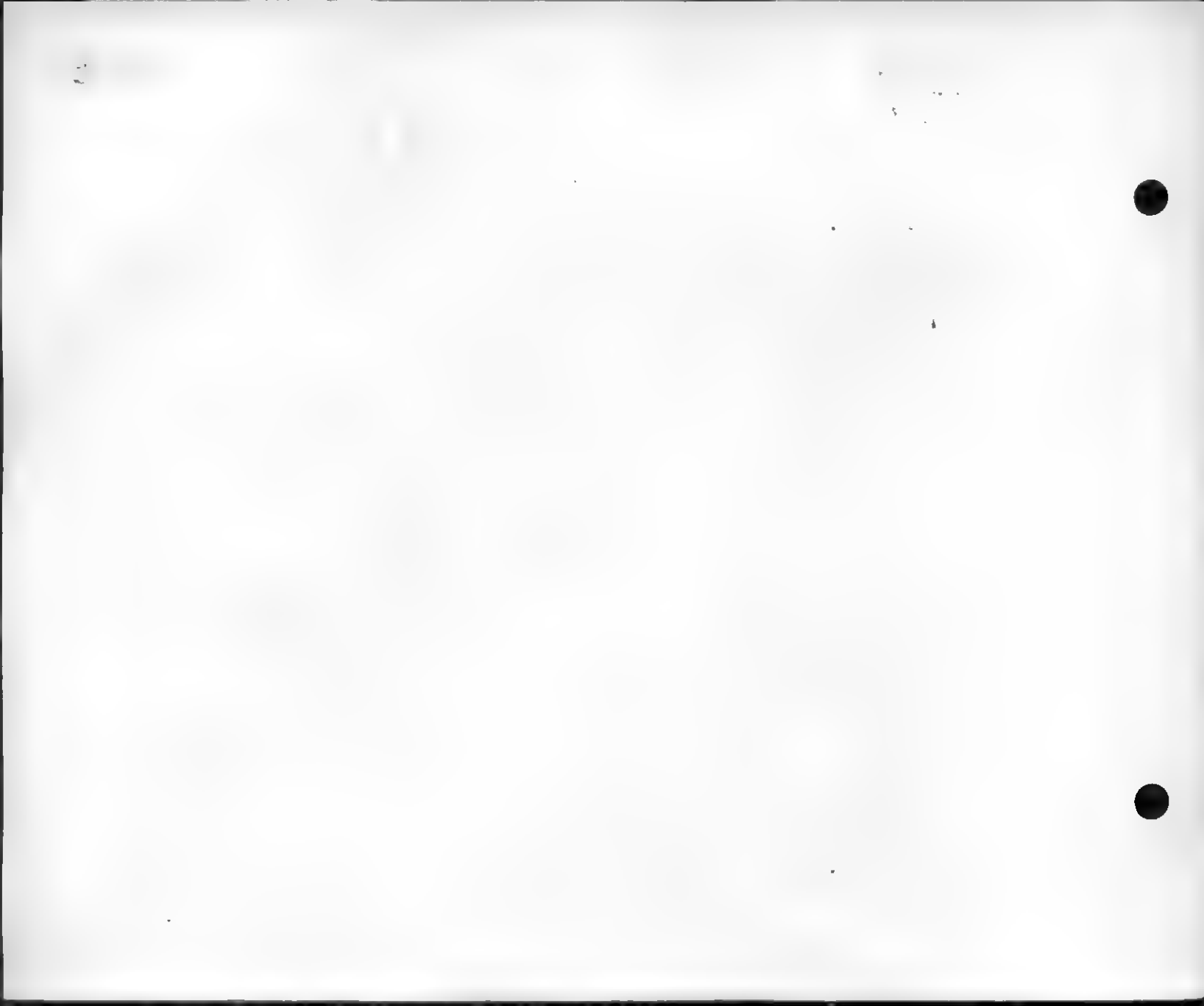
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be filed as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

M
I

74

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1 PLACE OF DEATH a COUNTY Allegany MARYLAND					2 USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) a STATE W. Va. b COUNTY Mineral				
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland			c LENGTH OF STAY in 1b ?		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Ashby				
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D. O. A. Sacred Heart Hospital					d STREET ADDRESS				e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) Ralph Vernon Marker			4 DATE OF DEATH Month May Day 6 Year 1967						
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH May 26, 1902		9 AGE (In years last birthday) 64 yrs	10 UNDER 1 YEAR Months 6 Days 19		11 UNDER 24 HRS Hours 67 Min 00	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Railroad			10b KIND OF BUSINESS OR INDUSTRY Retired Blacksmith		11 BIRTHPLACE (State or foreign country) Fort Ashby, W. Va.			12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME Jacob Marker					14 MOTHER'S MAIDEN NAME Atha Berry				
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no			16 SOCIAL SECURITY NO		17 INFORMANT Address Mr. Robert O. Billmyre, Fort Ashby, W. Va.				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Coronary Sclerosis CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) INTERVAL BETWEEN ONSET AND DEATH Sudden									
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Lymphosarcoma									19 WA AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)						
20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.			20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)		
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>Benedict Skitarelic</i> M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED May 7, 1967		
EXAMINER'S NAME (Type) Dr. Benedict Skitarelic, M. D.			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county) Rt. 9 Cumberland				
23c BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF May 8, 1967		23e NAME OF CEMETERY OR CREMATORY Fort Ashby Cemetery		23d LOCATION (City or town) (County) (State) Fort Ashby, W. Va. Mineral			
24 FUNERAL DIRECTOR ADDRESS James F. Scarpelli, Cumberland, Md.					25a REC'D BY REGISTRAR DATE MAY 11 1967		25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>		



1
FOR STATE
HEALTH DEPT.

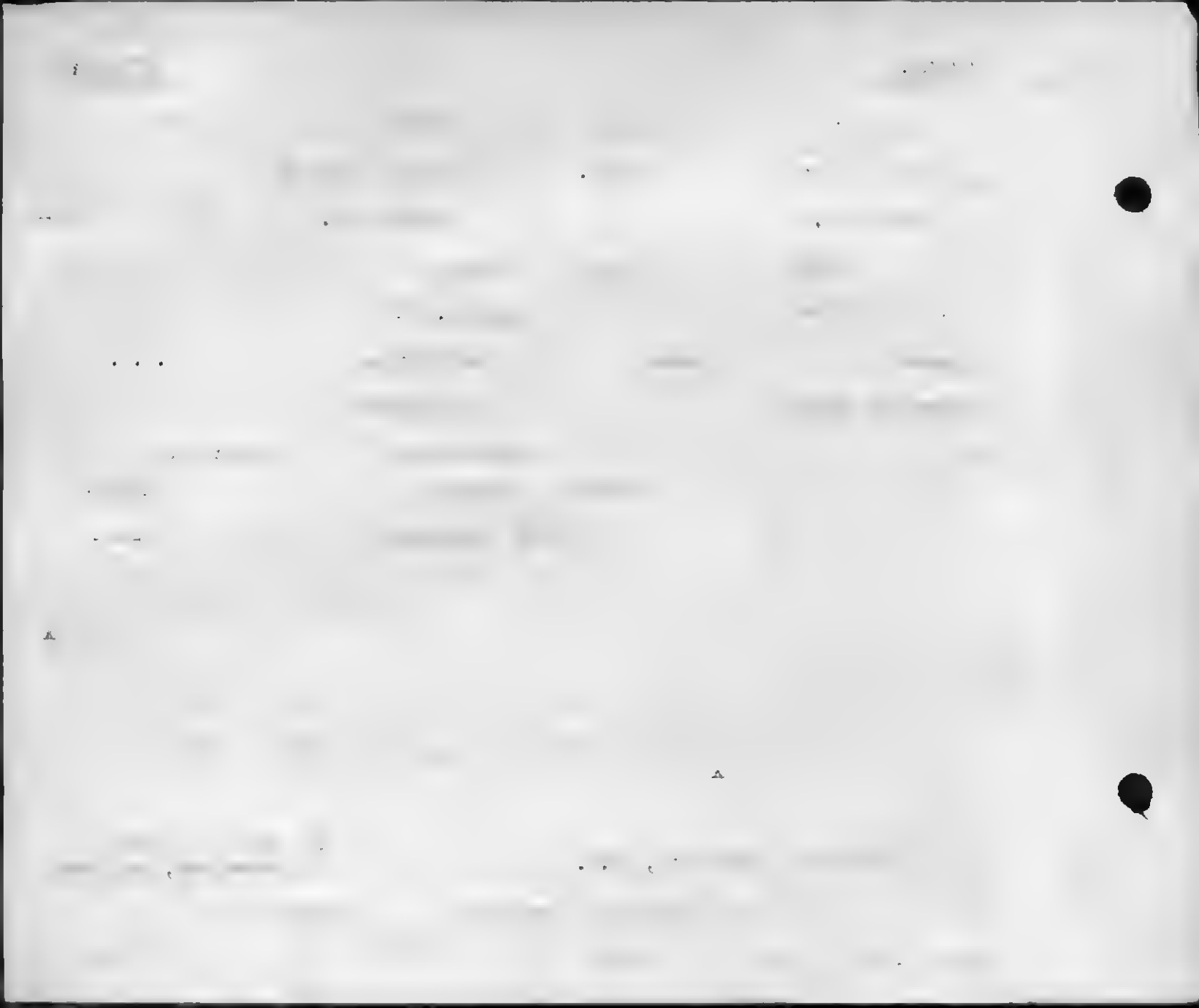
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

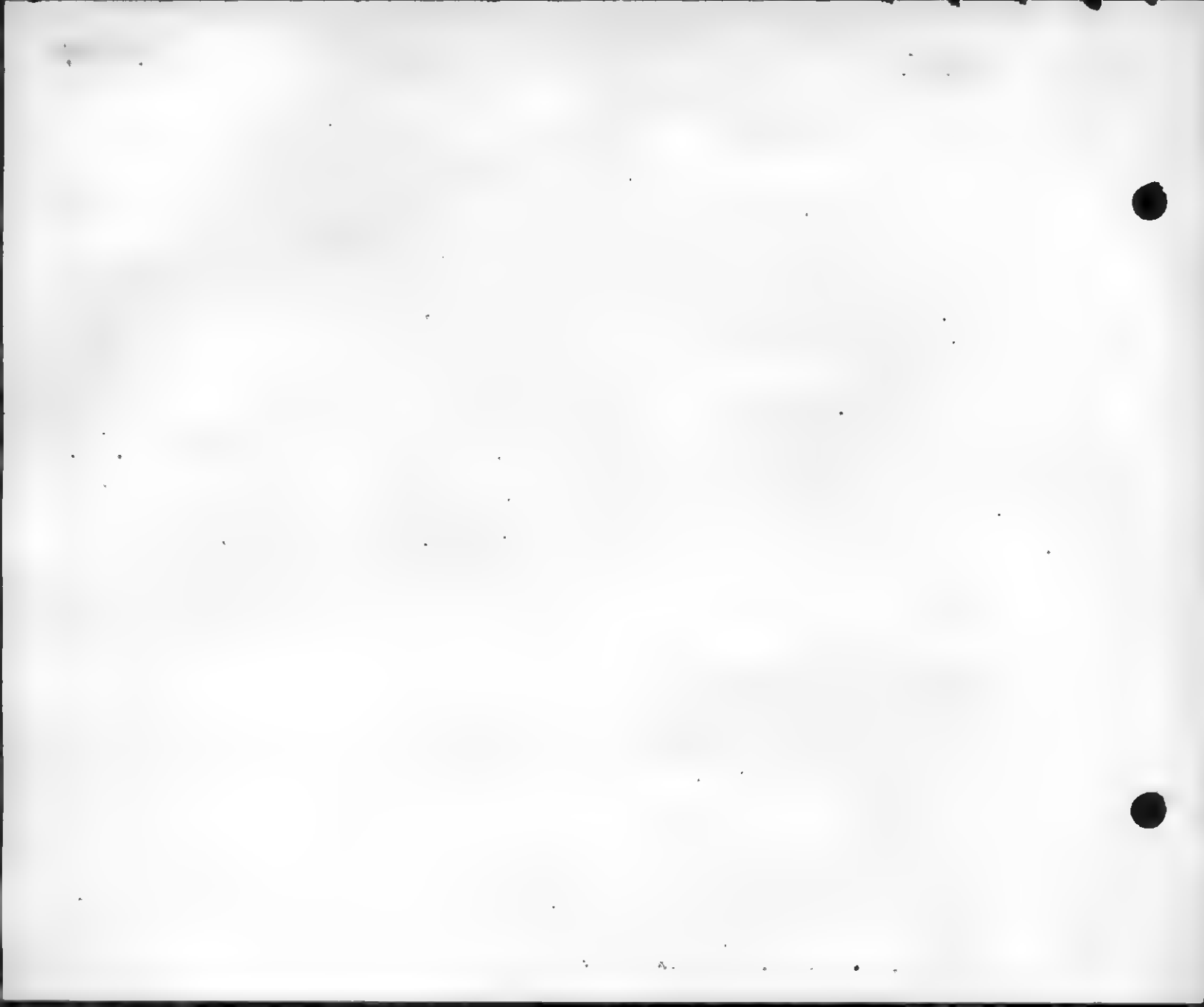
1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oldtown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oldtown Maryland	
c. LENGTH OF STAY in 1b 20 yrs.		d. STREET ADDRESS Oldtown Md.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Oldtown Md.		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Dory	4. DATE OF DEATH May 16, 1967	5. SEX Male	
6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 14, 1905	
9. AGE (In years last birthday) 61 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	11. BIRTHPLACE (State or foreign country) West Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.	13. FATHER'S NAME Luthen Mc Bride	14. MOTHER'S MAIDEN NAME Elsie Kidwell	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. —	17. INFORMANT Cleo Mc Bride	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) CORONARY OCCLUSION		INTERVAL BETWEEN ONSET AND DEATH SUDDEN	
DUE TO (b) CORONARY SCLEROSIS			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) —			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) —			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —	
20c. TIME OF INJURY Month, Day, Year May 19, 67	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —	20f. (City or town) Oldtown Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Benedict Skitarelic		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> May 16, 1967	
22b. DATE THEREOF May 19, 67	22c. NAME OF CEMETERY OR CREMATORY Pine Hill Cemetery	Address (Street, city, town, or country) Cumberland, Maryland	
22d. LOCATION (City, town, or country) Oldtown Md.	24a. REC'D BY REGISTRAR MAY 22 1967		
23. FUNERAL DIRECTOR Louis Stein Inc.		24b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
06051 CERTIFICATE OF DEATH 06540											
1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>MARYLAND</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>McCoole</u>						c. LENGTH OF STAY IN ID <u>3 Wks</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>McMullen Highway</u>						d. STREET ADDRESS <u>749 Maryland Avenue</u>					
3. NAME OF DECEASED (Type or print) <u>Mary Katherine McFarland</u>						4. DATE OF DEATH <u>May 19 19 67</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 3, 1907</u>		9. AGE (In years last birthday) <u>59</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>						10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Mark E. Free</u>						14. MOTHER'S MAIDEN NAME <u>Emily Virginia Kuhn</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)						16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. Virginia Northcraft Keyser, W. Va.</u> Address <u>Route 3, Box 41A</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma from</u> DUE TO (b) <u>Lft. Breast (Carcinoma, scirrhous)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)											
INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Nov 16</u> , 19 <u>64</u> , to <u>May 19</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>4-25</u> 19 <u>67</u> , and that death occurred at <u>4:45 PM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Carlton Brinsfield</u>						22b. DATE SIGNED <u>5-20-67</u>					
22c. PHYSICIAN'S NAME (Type) <u>CARLTON BRINSFIELD MD</u>						22d. ADDRESS <u>401 DECATUR ST.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>May 23, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Prosperity Methodist Cem</u>		23d. LOCATION (City, town or county) (State) <u>Near Cumberland, Maryland</u>			
24. FUNERAL DIRECTOR <u>John J. Hoffer, Jr.</u>						25a. REC'D BY REGISTRAR <u>MAY 24 1967</u>					
25b. REGISTRAR'S SIGNATURE <u>John J. Hoffer, Jr.</u>											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 14 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove urban papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

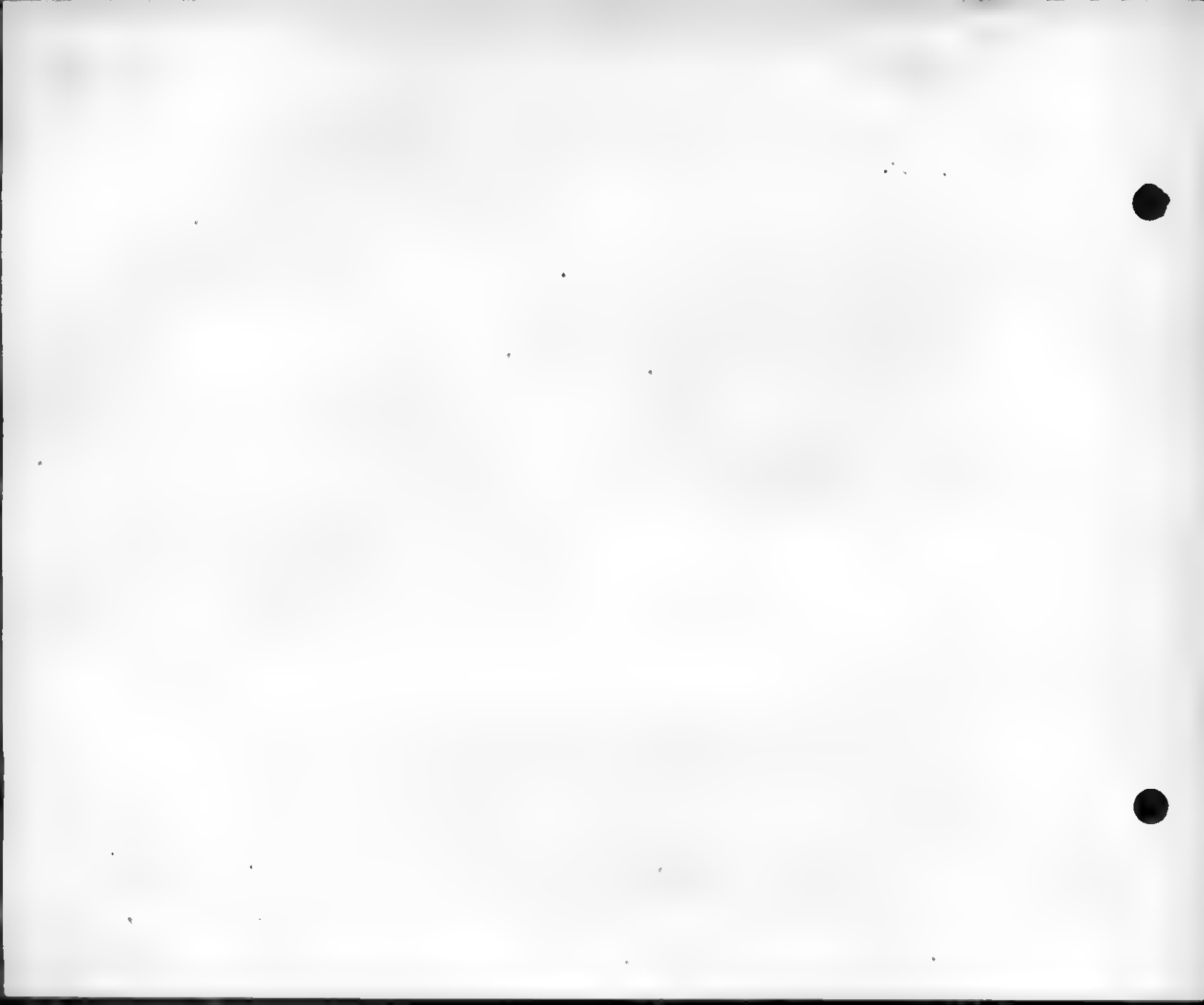
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06052

06041

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 16 DAYS			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL				d. STREET ADDRESS 308 COLUMBIA ST.			
3. NAME OF DECEASED (Type or print) First THOMAS Middle Gordon Last MC GINN				4. DATE OF DEATH Month MAY Day 1 Year 19 67			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-2-1928	
9. AGE (in years lost birthday) yrs 38		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Assoc. Amer. Trucking		11. BIRTHPLACE (County & State, or foreign country) FROSTBURG, MD.	
13. FATHER'S NAME WILLIAM MC GINN				14. MOTHER'S MAIDEN NAME ANNA HOLSINGER			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO 213-24-669.3		17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.	
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hepatic Failure 10 DUE TO Cirrhosis of Liver Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 2 months (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Duodenal ulcer						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> of work		20e. PLACE OF INJURY (Home; farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 15 Apr 1967 to 1 May 1967 , that (I) (we) last saw the deceased alive on 1 May 1967 , and that death occurred at 10:40 PM from causes and on the date stated above.							
22a. SIGNATURE Andrew Stasko				22b. DATE SIGNED 5/3/67		22c. PHYSICIAN'S NAME (Type) ANDREW STASKO, M.D.	
22d. ADDRESS 401 DECATUR ST., CUMBERLAND, MD.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/4/67		23c. NAME OF CEMETERY OR CREMATORY Eckhart Cemetery		23d. LOCATION (City or Town) (County) (State) Eckhart, Allegany, Maryland	
24. FUNERAL DIRECTOR H. Wayne George Cumberland, Maryland				25a. REC'D BY REGISTRAR MAY 5 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06053

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

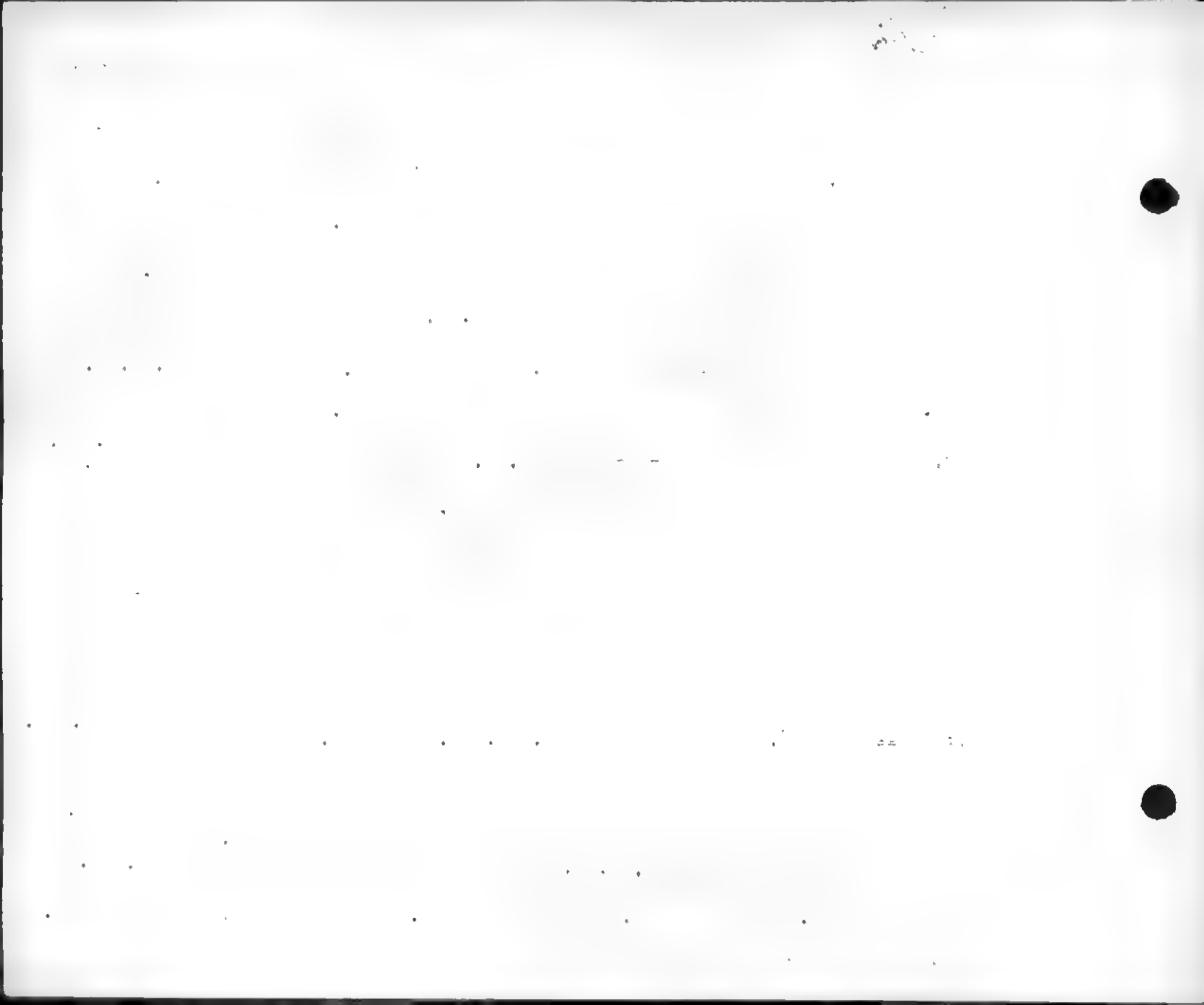
15012

FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a COUNTY Allegany MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE Maryland b COUNTY Allegany	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c LENGTH OF STAY IN 1b 10 Minutes	c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Box 51 E Fairgo, Cumberland,
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital		d STREET ADDRESS Division Ave.	
3 NAME OF DECEASED (Type or print) First William Middle Leo Last McKenzie		4 DATE OF DEATH Month May Day 14 Year 19 67	
5 SEX Male	6 COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Jan. 5, 1948
9 AGE (In years last birthday) yrs. 19		IF UNDER 1 YEAR Months 1 Days 14 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY Painting Contr.	11 BIRTHPLACE (State or foreign country) Cumberland, Maryland
12 CITIZEN OF WHAT COUNTRY? U. S. A.		13 FATHER'S NAME P. William McKenzie	
14 MOTHER'S MAIDEN NAME Margaret T. Flynn		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16 SOCIAL SECURITY NO. 218-48-9995		17 INFORMANT Mr. P. William McKenzie Box 51E Fairgo,	
18 ADDRESS Cumb. Md.		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
1b CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemothorax, Left DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Ruptured Left Lung DUE TO (c) Compression of Chest		INTERVAL BETWEEN ONSET AND DEATH Minutes Sudden ----	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b) Driver in a one car accident	
20c. TIME OF INJURY Month, Day Year 9:00 May 14, 1967		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work W. Va. Rt. # 28	
20e. PLACE OF INJURY (Home form factory, street, off highway, etc.) Nr. Fort Ashby Hampshire,		20f. (City or town) (County) (State) W. Va.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. DATE SIGNED May 14, 1967	
ACTUAL SIGNATURE Benedict Skitarelic		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Benedict Skitarelic, M. D.		ASSISTANT MED. EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Rt. # 9 Cumberland, Md.	
Address (Street, city, town or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5/17/67	23c. NAME OF CEMETERY OR CREMATORY SS. Peter & Paul Cem.	23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany Md.
24. FUNERAL DIRECTOR H. Wayne George Cumberland, Maryland		25a. REC'D BY REG. STRAR MAY 18 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06054

00043

1 PLACE OF DEATH a COUNTY ALLEGANY MARYLAND		2 USUAL RESIDENCE (Where deceased lived, f institution Residence before admission) a. STATE MARYLAND b COUNTY ALLEGANY	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c LENGTH OF STAY IN 1b 27 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		d STREET ADDRESS BOX 294, BARTON, MD.	
3 NAME OF DECEASED (Type or print) First MARY Middle M. Last MC VICKER		4 DATE OF DEATH Month MAY Day 14 Year 1967	
5 SEX FEMALE	6 COLOR OR RACE WHITE	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 9-17-90
9 AGE (In years last birthday) 76 yrs		10 IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) DAWSON, MD.		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME EVAN SIGLER		14. MOTHER'S MAIDEN NAME MARY A. FORTHMAN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16 SOCIAL SECURITY NO	
17 INFORMANT MEMORIAL HOSPITAL		Address CUMBERLAND, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Generalized Arterio Sclerosis DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 1-16-67
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 4-16-67 to 5-14-67 , that (I) last saw the deceased alive on 5-13-67 , and that death occurred at 6:25A M, from causes and on the date stated above.			
22a SIGNATURE Wm. F. Williams		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22b DATE SIGNED 5-15-67
22c PHYSICIAN'S NAME (Type) DR. W. F. WILLIAMS		22d ADDRESS 122 S. CENTRE ST., CUMBERLAND, MD	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF 5/16/67	23c NAME OF CEMETERY OR CREMATORY Philos	23d LOCATION (City or Town) (County) (State) Westernport Md.
24 FUNERAL DIRECTOR E. J. Boral		ADDRESS Westernport, Md.	25a REC'D BY REGISTRAR MAY 18 1967
		25b REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 22 hours after death.

VR A15 (4)
2DM 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
36055 Items #16, c, 103-104-105-106-107-108-109-110-111-112-113-114-115-116-117-118-119-120-121-122-123-124-125-126-127-128-129-130-131-132-133-134-135-136-137-138-139-140-141-142-143-144-145-146-147-148-149-150-151-152-153-154-155-156-157-158-159-160-161-162-163-164-165-166-167-168-169-170-171-172-173-174-175-176-177-178-179-180-181-182-183-184-185-186-187-188-189-190-191-192-193-194-195-196-197-198-199-200-201-202-203-204-205-206-207-208-209-210-211-212-213-214-215-216-217-218-219-220-221-222-223-224-225-226-227-228-229-230-231-232-233-234-235-236-237-238-239-240-241-242-243-244-245-246-247-248-249-250-251-252-253-254-255-256-257-258-259-260-261-262-263-264-265-266-267-268-269-270-271-272-273-274-275-276-277-278-279-280-281-282-283-284-285-286-287-288-289-290-291-292-293-294-295-296-297-298-299-300-301-302-303-304-305-306-307-308-309-310-311-312-313-314-315-316-317-318-319-320-321-322-323-324-325-326-327-328-329-330-331-332-333-334-335-336-337-338-339-340-341-342-343-344-345-346-347-348-349-350-351-352-353-354-355-356-357-358-359-360-361-362-363-364-365-366-367-368-369-370-371-372-373-374-375-376-377-378-379-380-381-382-383-384-385-386-387-388-389-390-391-392-393-394-395-396-397-398-399-400-401-402-403-404-405-406-407-408-409-410-411-412-413-414-415-416-417-418-419-420-421-422-423-424-425-426-427-428-429-430-431-432-433-434-435-436-437-438-439-440-441-442-443-444-445-446-447-448-449-450-451-452-453-454-455-456-457-458-459-460-461-462-463-464-465-466-467-468-469-470-471-472-473-474-475-476-477-478-479-480-481-482-483-484-485-486-487-488-489-490-491-492-493-494-495-496-497-498-499-500-501-502-503-504-505-506-507-508-509-510-511-512-513-514-515-516-517-518-519-520-521-522-523-524-525-526-527-528-529-530-531-532-533-534-535-536-537-538-539-540-541-542-543-544-545-546-547-548-549-550-551-552-553-554-555-556-557-558-559-560-561-562-563-564-565-566-567-568-569-570-571-572-573-574-575-576-577-578-579-580-581-582-583-584-585-586-587-588-589-590-591-592-593-594-595-596-597-598-599-600-601-602-603-604-605-606-607-608-609-610-611-612-613-614-615-616-617-618-619-620-621-622-623-624-625-626-627-628-629-630-631-632-633-634-635-636-637-638-639-640-641-642-643-644-645-646-647-648-649-650-651-652-653-654-655-656-657-658-659-660-661-662-663-664-665-666-667-668-669-670-671-672-673-674-675-676-677-678-679-680-681-682-683-684-685-686-687-688-689-690-691-692-693-694-695-696-697-698-699-700-701-702-703-704-705-706-707-708-709-710-711-712-713-714-715-716-717-718-719-720-721-722-723-724-725-726-727-728-729-730-731-732-733-734-735-736-737-738-739-740-741-742-743-744-745-746-747-748-749-750-751-752-753-754-755-756-757-758-759-760-761-762-763-764-765-766-767-768-769-770-771-772-773-774-775-776-777-778-779-780-781-782-783-784-785-786-787-788-789-790-791-792-793-794-795-796-797-798-799-800-801-802-803-804-805-806-807-808-809-810-811-812-813-814-815-816-817-818-819-820-821-822-823-824-825-826-827-828-829-830-831-832-833-834-835-836-837-838-839-840-841-842-843-844-845-846-847-848-849-850-851-852-853-854-855-856-857-858-859-860-861-862-863-864-865-866-867-868-869-870-871-872-873-874-875-876-877-878-879-880-881-882-883-884-885-886-887-888-889-890-891-892-893-894-895-896-897-898-899-900-901-902-903-904-905-906-907-908-909-910-911-912-913-914-915-916-917-918-919-920-921-922-923-924-925-926-927-928-929-930-931-932-933-934-935-936-937-938-939-940-941-942-943-944-945-946-947-948-949-950-951-952-953-954-955-956-957-958-959-960-961-962-963-964-965-966-967-968-969-970-971-972-973-974-975-976-977-978-979-980-981-982-983-984-985-986-987-988-989-990-991-992-993-994-995-996-997-998-999-1000

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 17 32 YEARS	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SACRED HEART HOSPITAL		d. STREET ADDRESS P.O. BOX 537, CUMB., MD.	
3. NAME OF DECEASED (Type or print) WALTER FRANCIS MEADE		4. DATE OF DEATH Month 5 Day 5 Year 19 67	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-18-06
9. AGE (in years last birthday) 61 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 6 Days 1 Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Kelly Springfield Inc.		10b. KIND OF BUSINESS OR INDUSTRY SR. CLERK	
11. BIRTHPLACE (County & State, or foreign country) NEW YORK, N. Y.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME RICHARD MEADE		14. MOTHER'S MAIDEN NAME MATHILDA (REITH)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 214-07-0834	
17. INFORMANT Hospital Admns - Address		18. RECORDS	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage secondary to DUE TO (b) insertion of Y graft from terminal DUE TO (c) aorta to femoral artery because of bleed PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Syndrome			
19. INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.			
22a. SIGNATURE DR. E. R. PAUL		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) DR. E. R. PAUL		22d. ADDRESS 36 GREENE ST., CUMB., MD. 21502	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 5/8/67	23c. NAME OF CEMETERY OR CREMATORY St. Patrick's Cem.	23d. LOCATION (City, town or county) (State) Mt. Savage Md.
24. FUNERAL DIRECTOR Louis Stein Inc. Cumb. Md.		25a. REC'D BY REGISTRAR MAY 8 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06056

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06045

1 PLACE OF DEATH a COUNTY Allegany MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE Maryland b COUNTY Allegany	
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Cumberland		c LENGTH OF STAY IN 1b 70 years	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 429 Homer Street		d STREET ADDRESS 429 Homer Street	
3 NAME OF DECEASED (Type or print) First Elsie Middle Marie Last Morris		4 DATE OF DEATH Month May Day 19 Year 1967	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH May 19, 1895 June 1, 1895
9 AGE (In years last birthday) 71 yrs		10 IF UNDER 1 YEAR Months 1 Days 18 Hours 18 Min 18	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b KIND OF BUSINESS OR INDUSTRY Own Home	
11 BIRTHPLACE (State or foreign country) Dobbins, W. Va.		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME John E. Squires		14 MOTHER'S MAIDEN NAME Katherine Kieffner	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give war or dates of service)		16 SOCIAL SECURITY NO	
17 INFORMANT Mr. Chester A. Squires, Cumberland, Md.		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4201 DUE TO CORONARY OCCLUSION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last CORONARY SCLEROSIS (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH SUDDEN ----	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)		20f (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Benedict Skitarelic EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> May 19, 1967 Address (Street, city, town, or county) Cumberland, Md.	
22. DATE SIGNED			
23a BURIAL (CREMATION, REMOVAL (Specify)) Burial		23b DATE THEREOF May 22, 1967	
23c NAME OF CEMETERY OR CREMATORY Greenmount Cemetery		23d LOCATION (City or town) (County) (State) Cumberland, Md. Allegany	
24 FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		25a REC'D BY REGISTRAR MAY 23 1967 DATE	
		25b REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

06057

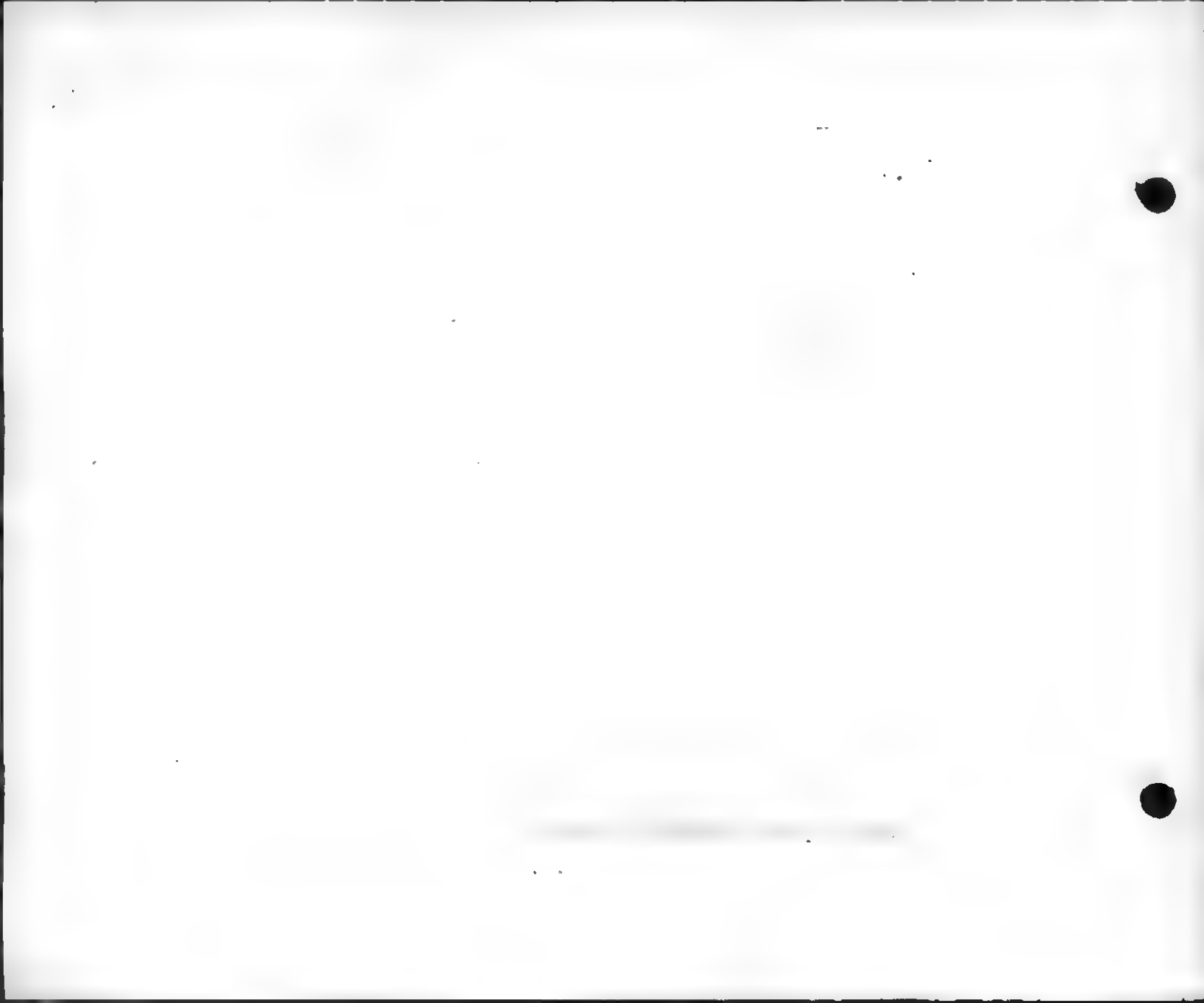
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06046

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY in 1b 71 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Hospital				d. STREET ADDRESS 18 Boone Street		e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Harry E. Nee				4. DATE OF DEATH Month Day Year May 25 19 67			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 31, 1895		9. AGE (In years last birthday) 71 yrs	f. UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Municipal		11. BIRTHPLACE (State or foreign country) Keyser, W. Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James A. Nee				14. MOTHER'S MAIDEN NAME Delia Lee			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes War I		16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. Florence Nee, Cumberland, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CORONARY OCCLUSION 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) Coronary Sclerosis DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 24 Hrs.	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Benedict Skitarelic		EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED May 25, 1967 Address (Street, city, town, or county) Cumberland, Md.	
23a. BURIAL CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF May 29, 1967		23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park		23d. LOCATION (City or town) (County) (State) Cumberland, Md. Allegany	
24. FUNERAL DIRECTOR ADDRESS James F. Scarpelli, Cumberland, Md.				25a. REC'D BY REGISTRAR DATE MA 31 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

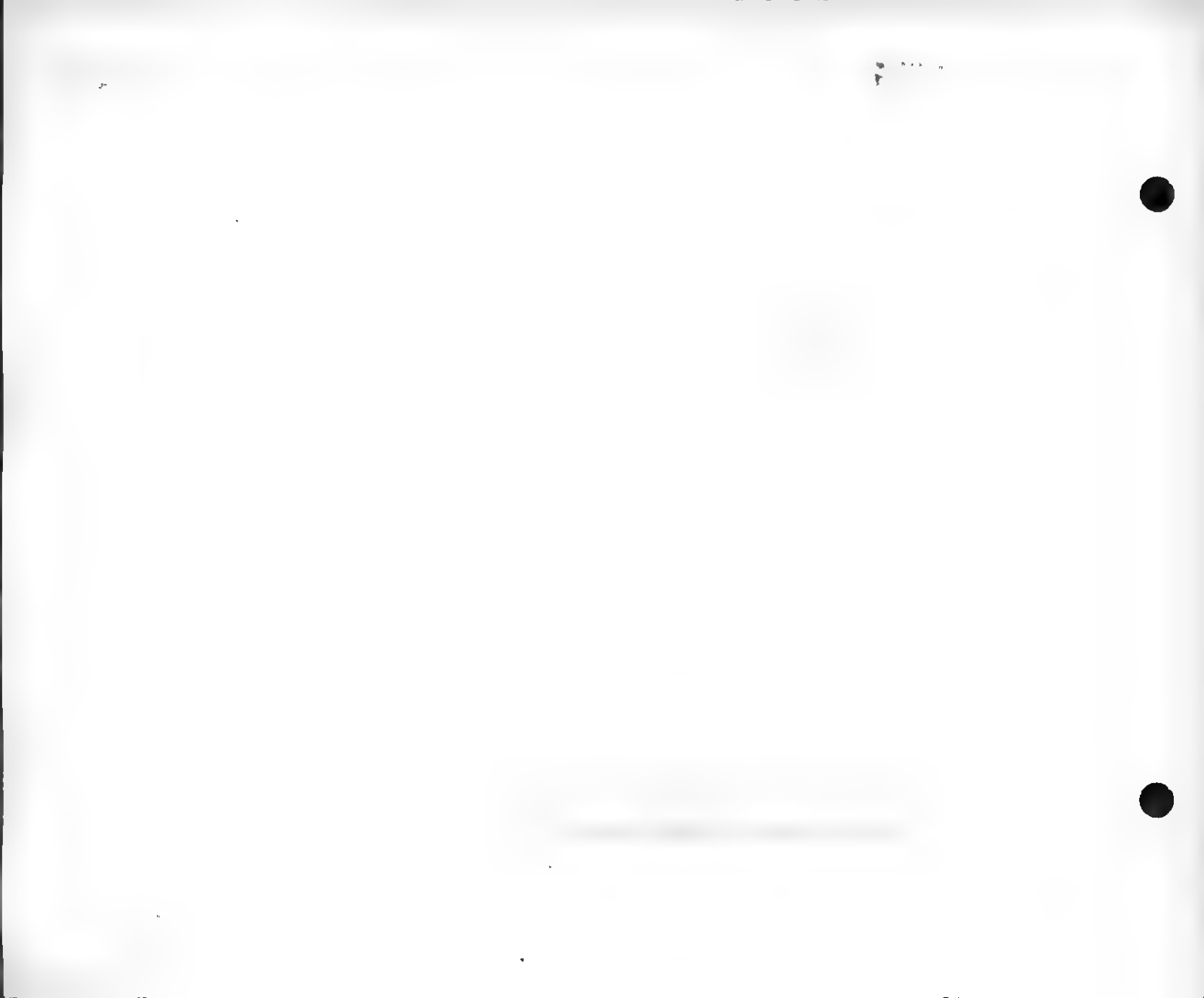
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1, 2, and 3 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15MF (5)
6M 1/66

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 66 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1 South Terrace		d. STREET ADDRESS 1 South Terrace	
3. NAME OF DECEASED (Type or print) First Joseph Middle Peter Last Nies		4. DATE OF DEATH Month May Day 16 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 15, 1900
9. AGE (In years last birthday) 66 yrs		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance		10b. KIND OF BUSINESS OR INDUSTRY Tire Industry	
11. BIRTHPLACE (State or foreign country) Cumberland, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Andrew Nies		14. MOTHER'S MAIDEN NAME Clara B. Sell	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give war or dates of service)		16. SOCIAL SECURITY NO. no	
17. INFORMANT Mrs. Leota Nies, Cumberland, Md.-Wife		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Coronary Sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) --- (c) ---			INTERVAL BETWEEN ONSET AND DEATH Sudden
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour am 19 pm	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Benedict Skitarelic M.D. EXAMINER'S NAME (Type) Dr. Benedict Skitarelic, M. D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MED. CAL. EXAMINER <input type="checkbox"/> May 16, 1967. DATE SIGNED DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Rt. 9 Cumberland Md. Address (Street, city, town or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF May 20, 1967	23c. NAME OF CEMETERY OR CREMATORY SS. Peter & Paul Cemetery	23d. LOCATION (City or Town) (County) (State) Cumberland, Md. Allegany
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		25a. REC'D BY REGISTRAR MAY 19 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

MEDICAL CERTIFICATE



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

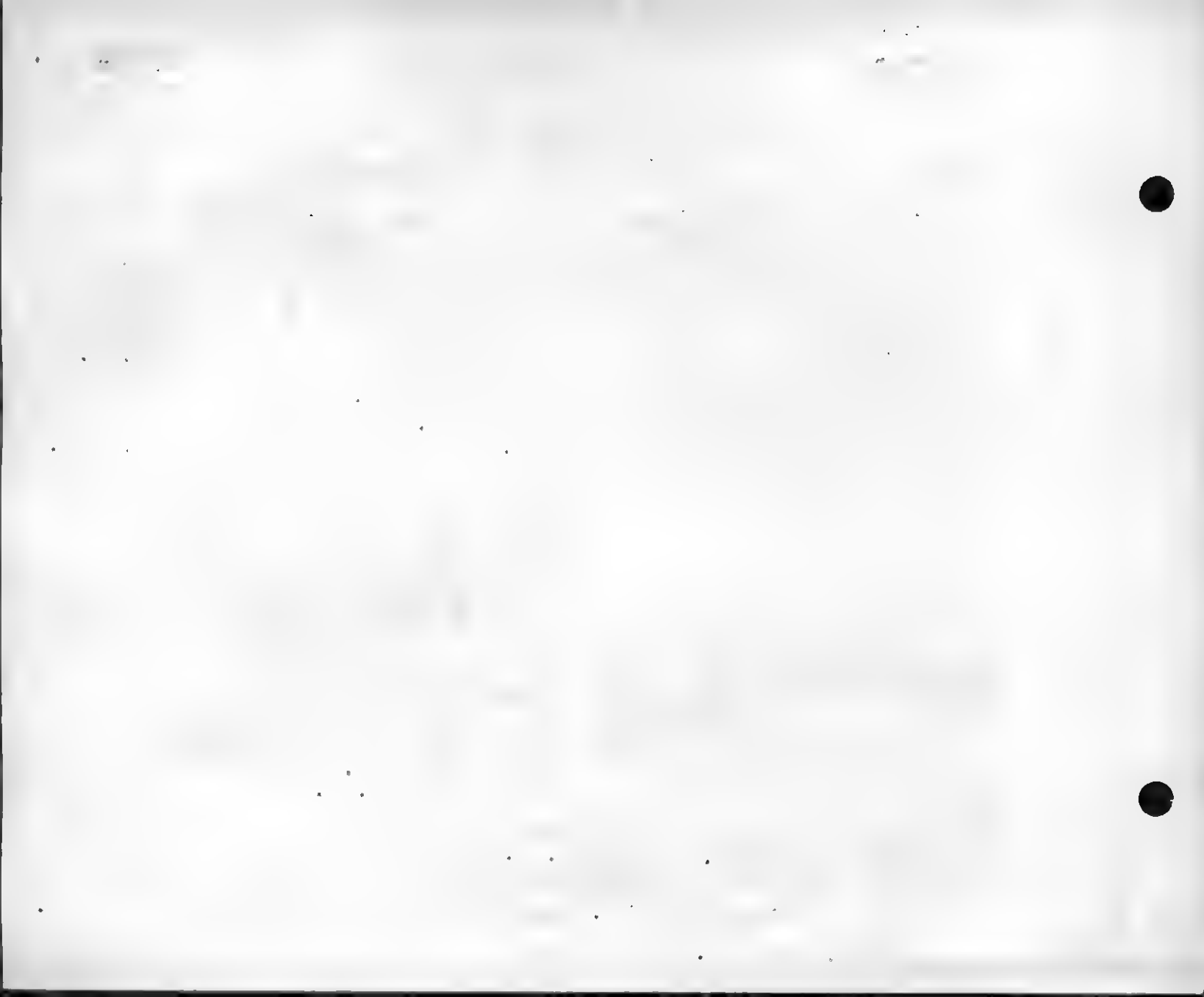
06059

CERTIFICATE OF DEATH

06048

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland			c. LENGTH OF STAY IN 1b 2/23/1967		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Allegany County Infirmary				d. STREET ADDRESS 26 Grant Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED First Middle Last Janet Penn Park (Type or print)				4. DATE OF DEATH Month Day Year May 20, 1967				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/2/1876		
9. AGE (In years last birthday) 90 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State or foreign country) Lonaconing, Maryland		
12. CITIZEN OF WHAT COUNTRY? U. S. A.				13. FATHER'S NAME William Taylor				
14. MOTHER'S MAIDEN NAME Jane Robertson				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				
16. SOCIAL SECURITY NO.				17. INFORMANT P. O. Box 599, Address: Cumberland, Md. Allegany County Infirmary records.				
18. CAUSE OF DEATH (Enter on any cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Myocardial Infarction DUE TO (c) Generalized Arteriosclerosis							INTERVAL BETWEEN ONSET AND DEATH Yes	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Paroxysmal Nocturnal Dyspnea							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 2/23/67 , 19 67 , to 5/20/67 , 19 67 , that (I) (we) last saw the deceased alive on 2/20/67 , 19 67 , and that death occurred at P. M. , from causes and on the date stated above.								
22a. SIGNATURE George M. Simons M.D.				22b. DATE SIGNED 5/22/1967		22c. PHYSICIAN'S NAME (Type) George M. Simons, M. D.		
22d. ADDRESS Memorial Hospital, Cumberland				23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				
23b. DATE THEREOF 5-24-67		23c. NAME OF CEMETERY OR CREMATORY F'bg. Memorial Park		23d. LOCATION (City or Town) (County) (State) Frostburg, Md.		24. FUNERAL DIRECTOR Joseph R. Durst, Sr., Frostburg, Md.		
25a. REC'D BY REGISTRAR MAY 25 1967				25b. REGISTRAR'S SIGNATURE Charles Judge				



FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

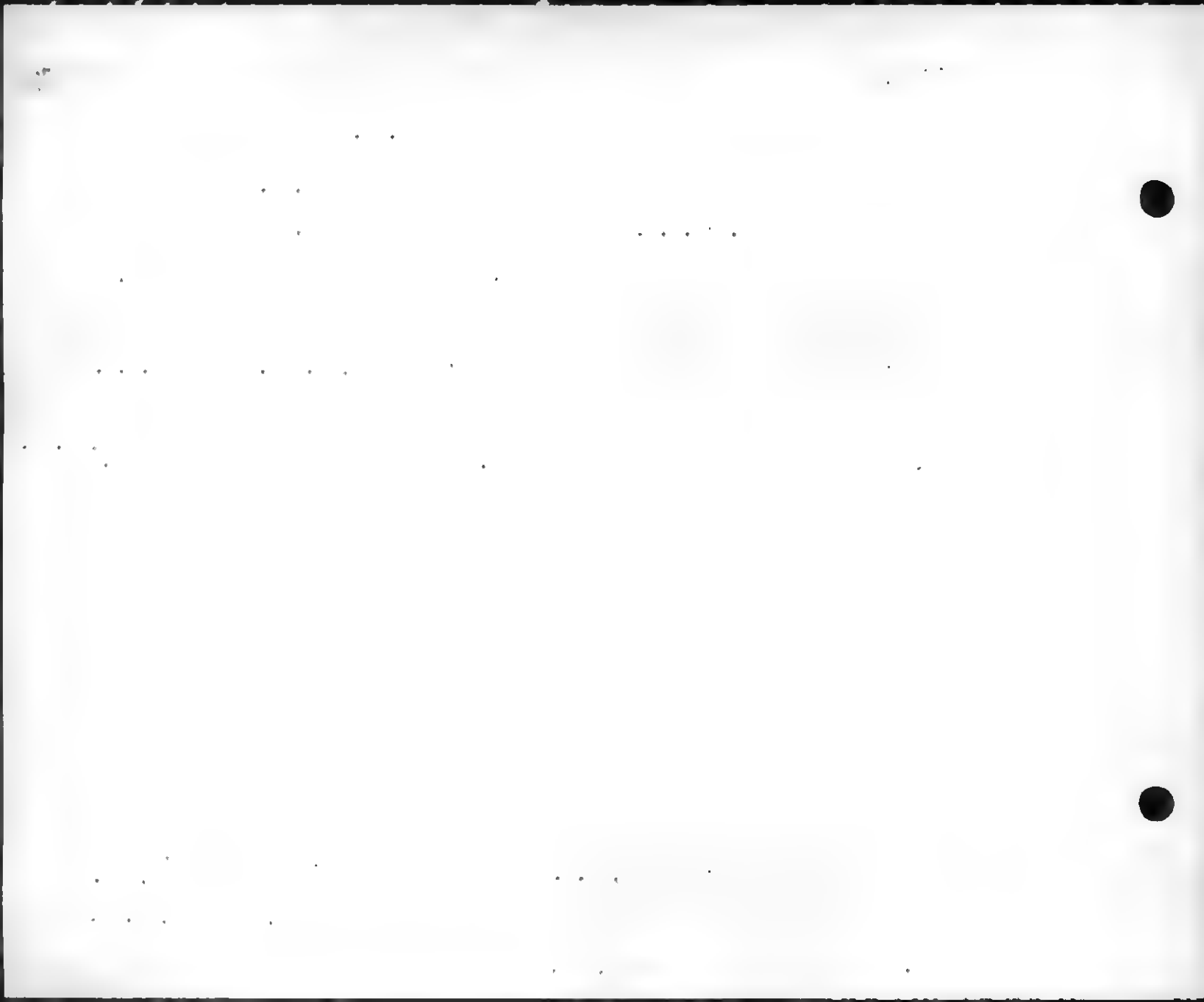
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06060

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06049

1 PLACE OF DEATH a COUNTY <u>Allegany</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) a. STATE <u>W. Va.</u> b. COUNTY <u>Mineral</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ridgeley, W. Va.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hosp. (D.O.A.)</u>		d. STREET ADDRESS <u>21 Mineral St.</u>	
3 NAME OF DECEASED (Type or print) First <u>Ella</u> Middle <u>Mae</u> Last <u>Parrish</u>		4 DATE OF DEATH Month <u>May</u> Day <u>13</u> Year <u>19 67</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>4/1/1881</u>
9 AGE (In years last birthday) <u>86</u> yrs		10 IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
11 US. AL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		12 KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
13. FATHER'S NAME <u>James Davis</u>		14. MOTHER'S MAIDEN NAME <u>Armanda Dixon</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO <u>None</u>	
17 INFORMANT <u>Mrs. Lloyd Ellifritz</u>		Address <u>Ridgeley, W. Va.</u> <u>21 Mineral St.</u>	
18 CAUSE OF DEATH (Enter only one cause per Part I. Death was caused by IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>CORONARY SCLEROSIS</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>SUDDEN</u>	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Notural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. DATE SIGNED MAY 13, 1967	
ACTUAL SIGNATURE <u>Benedict Skitarelic, M.D.</u> EXAMINER'S NAME (Type) <u>Benedict Skitarelic, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>Cumberland, Md.</u>	
23a. BURIAL, CREMATION, or other disposal (Specify) <u>Burial</u>	23b. DATE THEREOF <u>5/15/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Queens Point Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Keyser, Mineral, W. Va.</u>
24 FUNERAL DIRECTOR <u>H. Wayne George</u>		25a. REC'D BY REG. STRAR DATE <u>MAY 18 1967</u>	
ADDRESS <u>Cumberland, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06061

CERTIFICATE OF DEATH

06050

1 PLACE OF DEATH a. COUNTY <u>ALLEGANY</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>MARYLAND</u> b. COUNTY <u>GARRET</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FROSTBURG</u>				c. LENGTH OF STAY IN 1b <u>5 days</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>GARRETT MINERS HOSPITAL</u>				d. STREET ADDRESS <u>11</u>			
3 NAME OF DECEASED (Type or print) First <u>CLARA</u> Last <u>A. PETENBRINK</u>				4. DATE OF DEATH Month <u>5</u> Day <u>4</u> Year <u>1967</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 22 1993</u>	
9. AGE (In years last birthday) <u>83</u> yrs		10. IF UNDER 1 YEAR Months <u>6</u> Days <u>13</u> Hours <u></u> Min <u></u>		11. BIRTHPLACE (County & State, or foreign country) <u>SCOTTSVILLE, PA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		13. FATHER'S NAME <u>JACOB GEIGER</u>	
14. MOTHER'S MAIDEN NAME <u>MELINDA BITTNER</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u>194-03-1466</u>				17. INFORMANT <u>PAUL PETENBRINK</u> Address <u>16 GRINE ST. SCOTTSVILLE, PA.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CHRONIC BRAIN SYNDROME</u> DUE TO (b) <u>CIRCULATORY DISTURBANCE</u> DUE TO (c) <u>CEREBRAL ARTERIOSCLEROSIS</u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 YEARS</u> <u>5 YEARS</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>INTESTINAL OBSTRUCTION DUE TO FACAL IMPACTION</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>JUNE 13, 1964</u> to <u>MAY 4, 1967</u> that (I) (we) last saw the deceased alive on <u>MAY 4, 1967</u> , and that death occurred at <u>4:10 PM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>A. Paige Strong</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>A. PAIGE STRONG</u>				22d. ADDRESS <u>Frostburg, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>5-5-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>WHITE OAK</u>		23d. LOCATION (City or town) (County) (State) <u>WELLSBURG, SUMMERS, PA.</u>	
24. FUNERAL DIRECTOR <u>Mark Sant</u> <u>60 West Main</u> <u>Ben H. Montecant</u> <u>Frostburg, Md 21532</u> <u>After-Southern Funeral Home</u>				25a. REC'D BY REGISTRAR <u>MAY 9 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed with in 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 1 should be used as a burial-transit permit. File pages 1 on 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

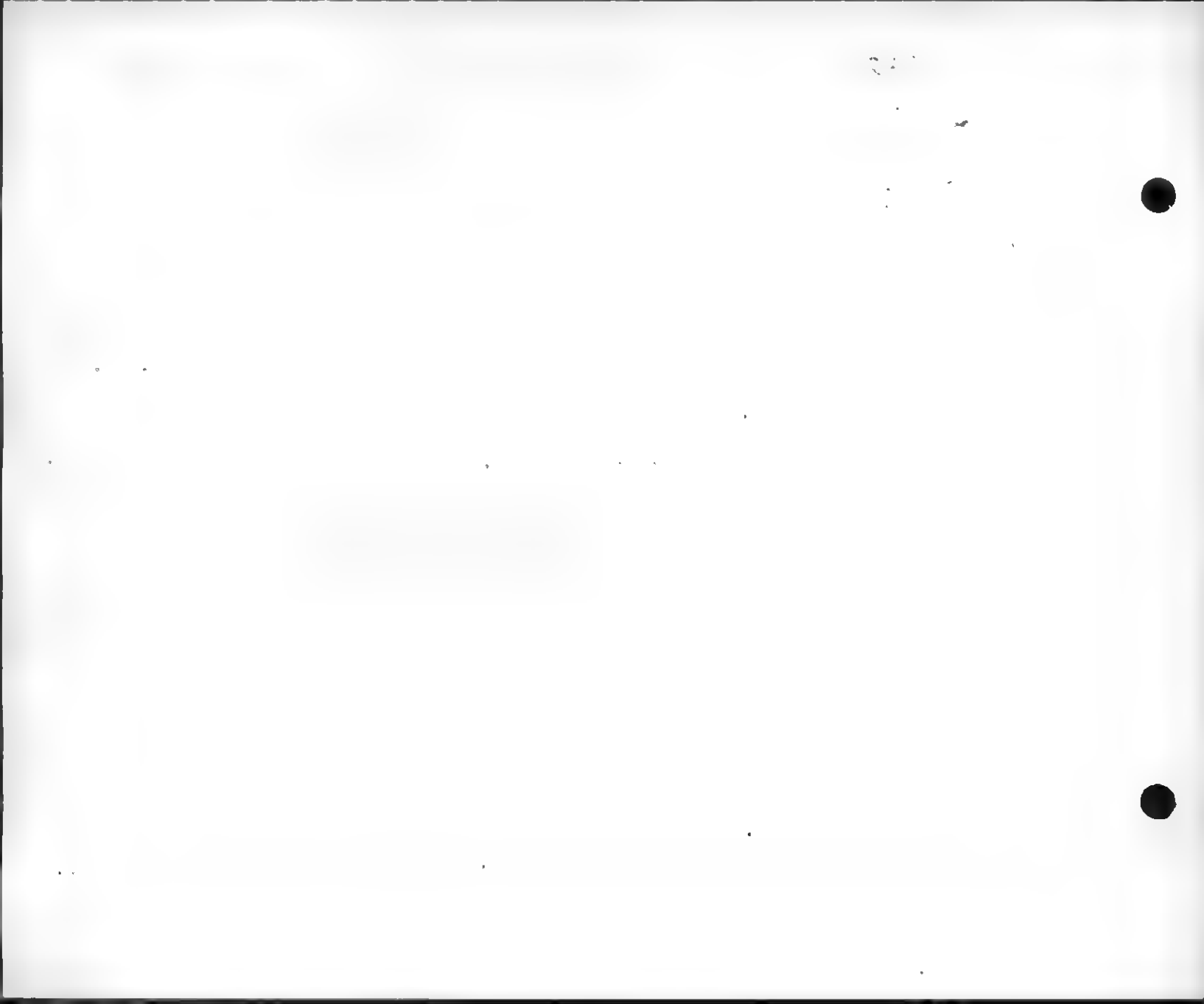
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06062

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06051

1 PLACE OF DEATH a. COUNTY Allegany MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE Maryland b COUNTY Allegany	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Flintstone Rt #2		c LENGTH OF STAY IN 'b 24 Years	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Pleasant Valley Road		e STREET ADDRESS Pleasant Valley Road	
3. NAME OF DECEASED (Type or print) Edgar Cecil Rephann		4. DATE OF DEATH Month May Day 24 Year 19 67	
5. SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH July 15, 1901
9 AGE (In years last birthday) 65 yrs		10 F UNDER 1 YEAR Months 19 Days 67 Hours 19 Min 67	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Meat Cutter		10b KIND OF BUSINESS OR INDUSTRY Eckhart Maryland	
11 BIRTHPLACE (State or foreign country) U.S.A.		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph E. Rephann		14. MOTHER'S MAIDEN NAME Martha Willison	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO 177-01-0733	
17 INFORMANT Mrs. Blanche Rephann		Address Route #2 Flintstone, Md	
8. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CORONARY OCCLUSION DUE TO (b) CORONARY THROMBOSIS DUE TO (c) CORONARY SCLEROSIS		INTERVAL BETWEEN ONSET AND DEATH SUDDEN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)		20f (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Benedict Skitarelic</i> EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.		22. DATE SIGNED May 27, 1967 CUMBERLAND, Md.	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF 5/27/67	
23c NAME OF CEMETERY OR CREMATORY Eckhart Cemetery		23d LOCATION (City or Town) (County) (State) Eckhart Allegany Maryland	
24 FUNERAL DIRECTOR H. Lee Silcox Cumberland Maryland 21502		25a REC'D BY REGISTRAR DATE MAY 29 1967	
25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

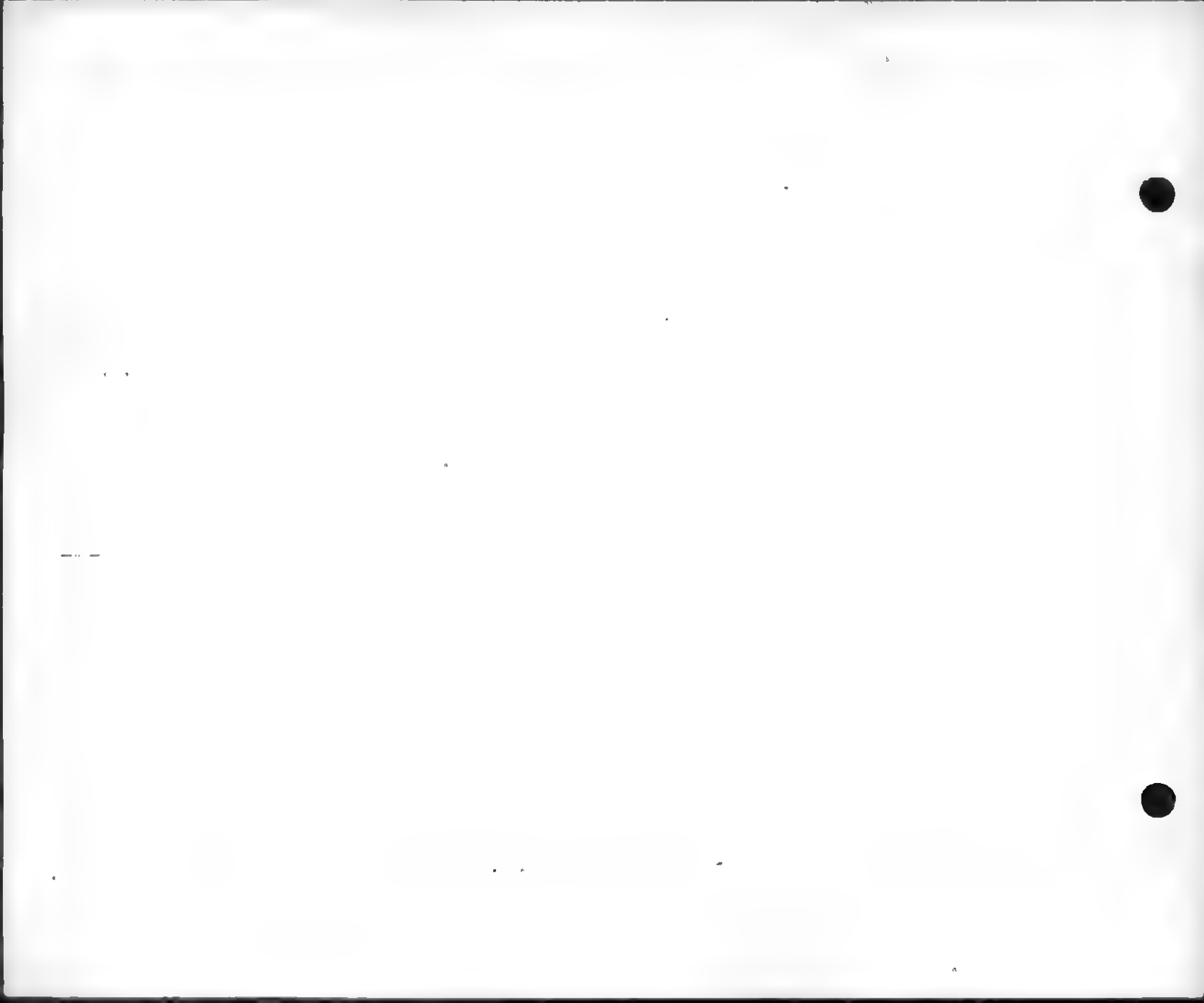
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06063

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06052

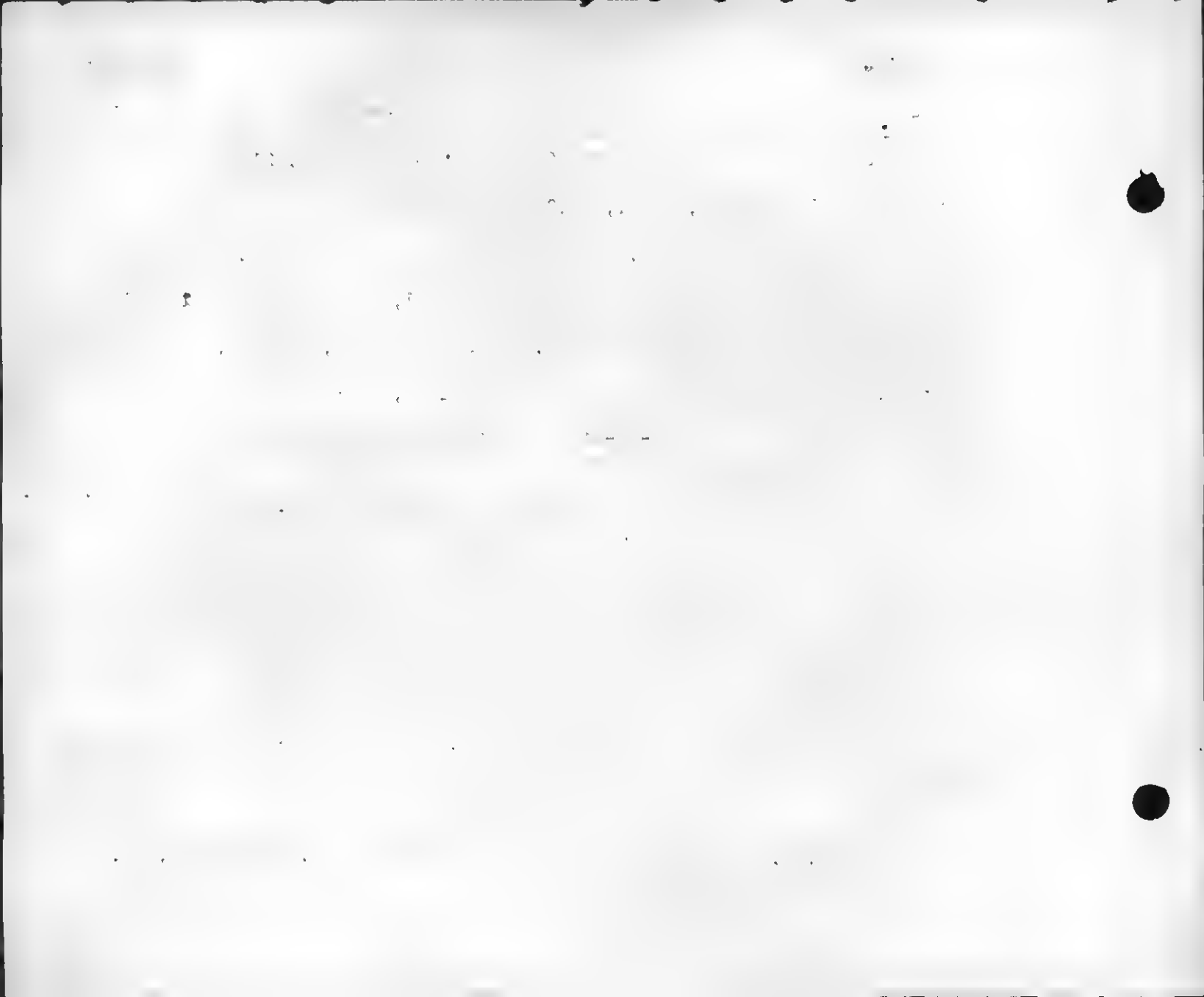
1 PLACE OF DEATH a COUNTY <u>Allegany</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Allegany</u>			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Flintstone Route #2</u>			c LENGTH OF STAY IN b <u>20 Years</u>			c CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Flintstone Route #2</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS		e IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>Joseph Ernest Rephann</u>				4 DATE OF DEATH Month Day Year <u>May 3 19 67</u>			
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W DOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 25, 1875</u>		9 AGE (In years last birthday) <u>92 yrs</u>	10 UNDER 1 YEAR Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Machinist</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Consolidated Coal Co</u>		11 BIRTHPLACE (State or foreign country) <u>Eckhart, Maryland</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>Henry Rephann</u>				14. MOTHER'S MAIDEN NAME <u>Mary Leidinger</u>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO <u>213-09-6488</u>		17 INFORMANT <u>Edgar C. Rephann</u>		Address <u>Route #2 Flintstone, Maryland</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>CORONARY OCCLUSION</u> (c) <u>CORONARY SCLEROSIS</u>						INTERVAL BETWEEN ONSET AND DEATH <u>SUDDEN</u>	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)						19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part or Part I of item 18)					
20c TIME OF INJURY Month, Day Year Hour a.m. p.m. <u>19</u>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspect an <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Benedict Skitarelic</u> M.D. EXAMINER'S NAME (Type) <u>BENEDICT SKITARELIC, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MED. CA. EXAMINER <input type="checkbox"/>		22. DATE SIGNED <u>May 3, 1967</u> Address (Street, city, town, or county) <u>Cumberland, Md.</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b DATE THEREOF <u>5/6/67</u>		23c NAME OF CEMETERY OR CREMATORY <u>Eckhart Cemetery</u>		23d LOCATION (City or Town) (County) (State) <u>Eckhart Allegany Maryland</u>	
24 FUNERAL DIRECTOR <u>H. Lee Silcox 404 Decatur St Cumberland, Md</u>				25a REC'D BY REGISTRAR DATE <u>MAY 8 1967</u>		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="display: flex; justify-content: space-between;"> 06064 MARYLAND STATE DEPARTMENT OF HEALTH 06053 </div> <div style="text-align: center;"> DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>											
1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN 1b 48 HOURS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL, CUMB., MD. 21502					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MD. 21502 d. STREET ADDRESS 39 WEMPE DRIVE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First JOHN Middle W. Last RHOE			4. DATE OF DEATH Month MAY Day 12 Year 1967								
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MARCH 11, 1904		9. AGE (in years last birthday) 63 yrs.		10. IF UNDER 1 YEAR Months 2 Days 1 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PIPE FITTER				10b. KIND OF BUSINESS OR INDUSTRY CELANESE CORP.		11. BIRTHPLACE (County & State, or foreign country) SLEEPY CREEK, WEST VA.			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME JOHN W. RHOE					14. MOTHER'S MATEON NAME MILLER, MARY ELLEN						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO			16. SOCIAL SECURITY NO. 214-07-4106		17. INFORMANT Address HOSPITAL ADMISSION FORM						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hypertensive Pulmonary</i> 15 DUE TO <i>Spontaneous Aortic Dissection involving unknown</i> (b) <i>Dissected aneurysm of</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <i>Pneumonia 3 years ago.</i> (c)										INTERVAL BETWEEN ONSET AND DEATH 3 days 3.67	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>May 10</i> , 19 67 to <i>May 12</i> , 19 67 that (I) (we) last saw the deceased alive on <i>May 12</i> , 19 67 and that death occurred at M , from the causes and on the date stated above.											
22a. SIGNATURE <i>B. M. Schindler</i>						22b. DATE SIGNED 5/11/67		22c. PHYSICIAN'S NAME (Type) DR. B. SCHINDLER		22d. ADDRESS 43 GREENE ST., CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF May 15, 1967		23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery			23d. LOCATION (City, town or county) (State) Cumberland, Md. Allegany		
24. FUNERAL DIRECTOR ADDRESS James F. Scarpelli, Cumberland, Md.						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			
						DATE MAY 17 1967					



HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

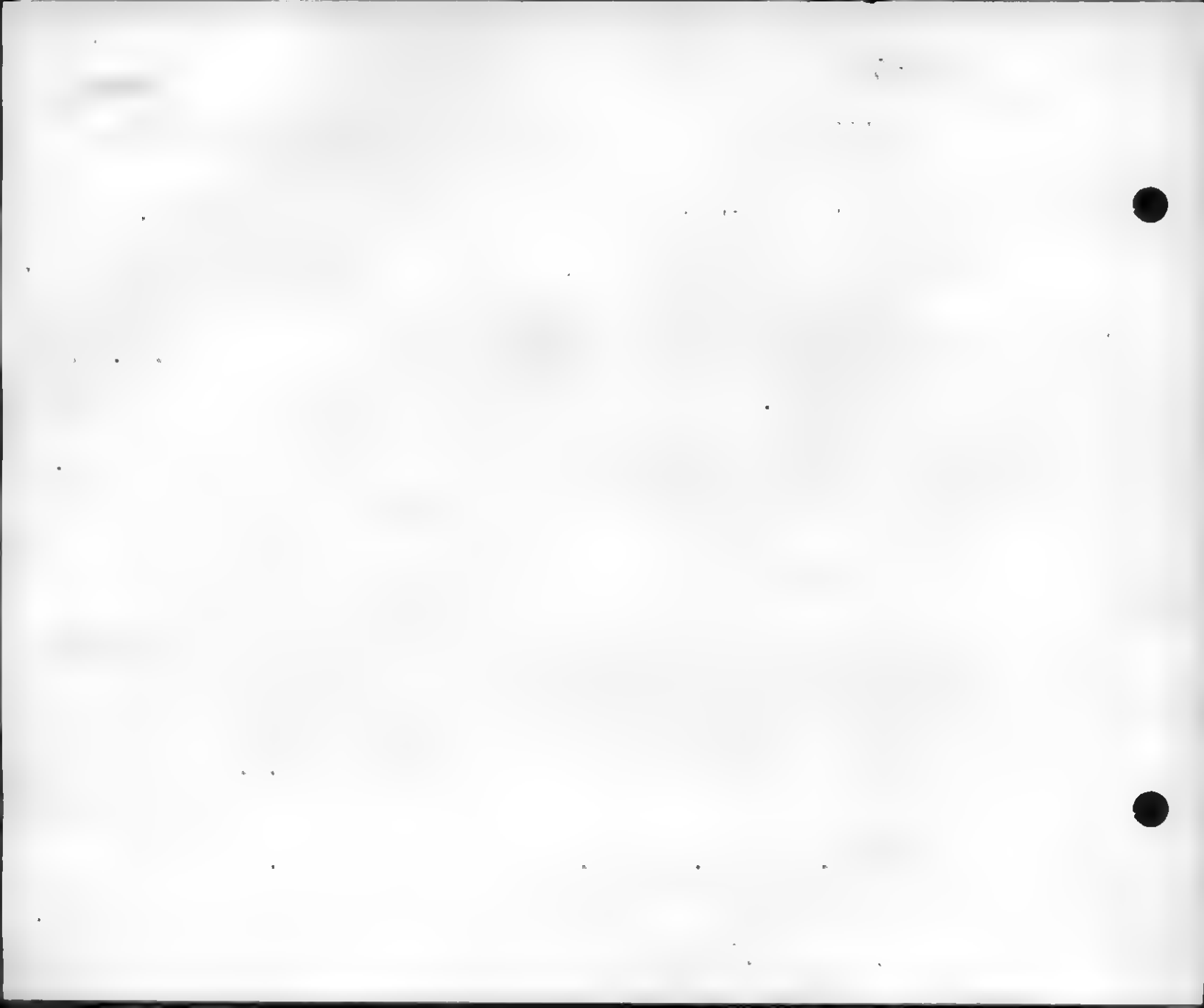
1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06065

CERTIFICATE OF DEATH

1 PLACE OF DEATH a COUNTY ALLEGANY MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c LENGTH OF STAY IN 1b 2 DAYS			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL				d. STREET ADDRESS 17 NORTH ALLEGANY ST.			
3 NAME OF DECEASED (Type or print) First WALTER Middle L. Last SCHACK				4 DATE OF DEATH Month MAY Day 28 Year 19 67			
5 SEX MALE	6 COLOR OR RACE WHITE	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 9-9-1900	9 AGE (In years last birthday) 66 yrs	IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Months Days Hours Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Head Draftsman			10b KIND OF BUSINESS OR INDUSTRY Fire Co Kelly Springfield		11 BIRTHPLACE (County & State, or foreign country) MISSOURI		12 CITIZEN OF WHAT COUNTRY? U.S. A.
13. FATHER'S NAME CHARLES F. SCHACK				14. MOTHER'S MAIDEN NAME IDA DAVID			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW 1			16. SOCIAL SECURITY NO. 492-03-8330		17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) adenocarcinoma Colon with metastasis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) to liver and terminal cachexia DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 3+ years	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arterio-sclerotic vascular disease with cerebral vascular accident						19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)				
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from August 1965 , 19 67 , that (I) (we) last saw the deceased alive on May 28, 1967 , and that death occurred at 8:30 p.m. , from causes and on the date stated above.							
22a. SIGNATURE Wylie M. Faw Jr.				ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED May 29 67	
22c. PHYSICIAN'S NAME (Type) DR. WYLIE M. FAW JR.				22d. ADDRESS CUMBERLAND, MD.			
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF 6/1/1967		23c NAME OF CEMETERY OR CREMATORY Frostburg Memorial Park		23d LOCATION (City or Town) (County) (State) Frostburg Alleg Md.	
24 FUNERAL DIRECTOR John J. Halter, Jr., 230 Balto Ave, Cumberland Md				25a REC'D BY REGISTRAR JUN 5 1967		25b REGISTRAR'S SIGNATURE Charles Judge	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

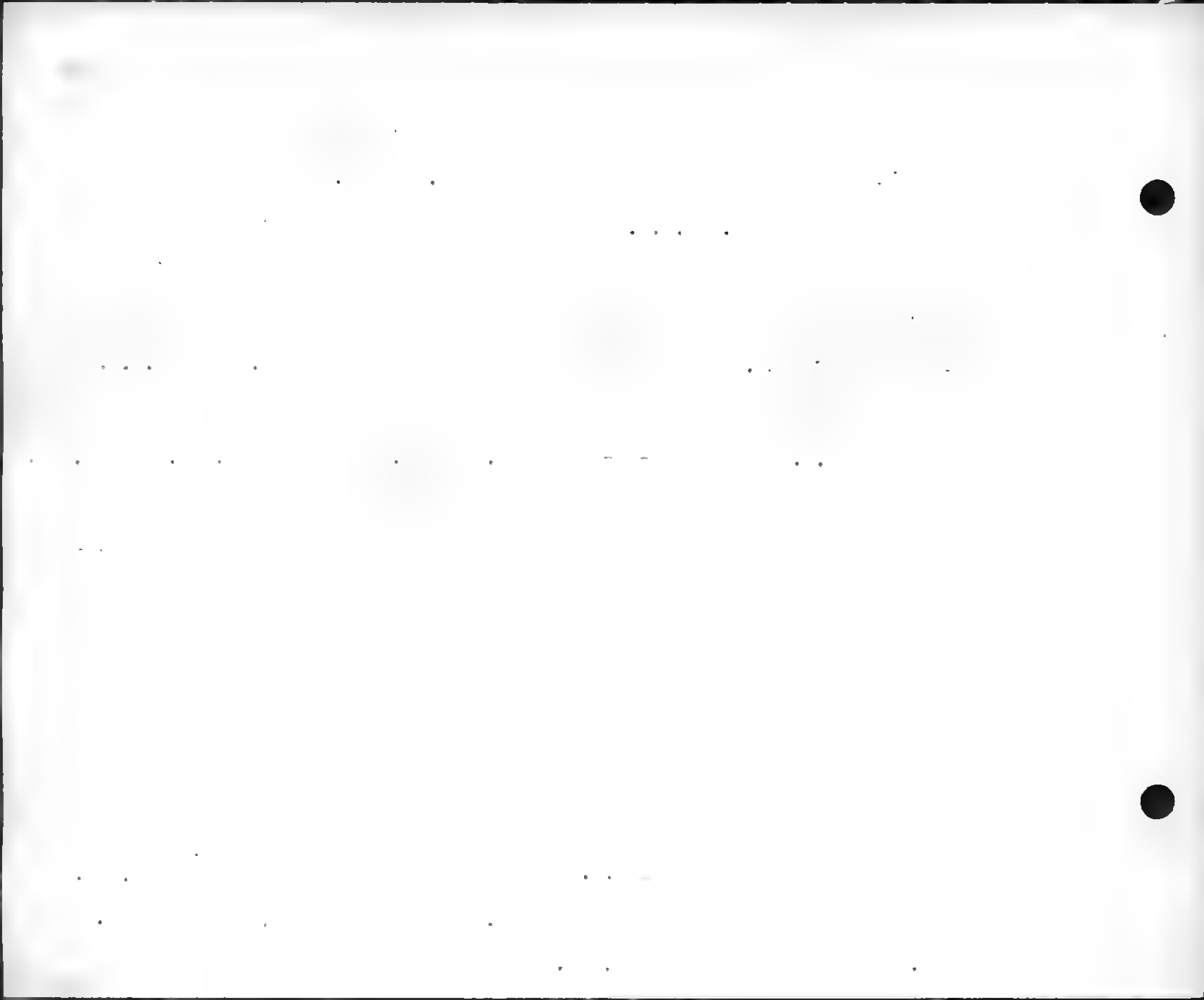
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06066

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06056

1 PLACE OF DEATH a. COUNTY <u>Allegany</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rt. # 1 Mt. Savage</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Sacred Heart Hosp. (D.O.A.)</u>		d. STREET ADDRESS <u>Community of Barreelsville</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <u>Peter</u> Middle <u>McKinley</u> Last <u>Shoemaker</u>		4 DATE OF DEATH Month <u>May</u> Day <u>12</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6 CO. OR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W. DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>12/10/1896</u> 9 AGE (In years last birthday) <u>70</u> F UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Utility Workman (Ret.)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Gas Company</u>	11 BIRTHPLACE (State or foreign country) <u>Meyersdale, Penna.</u> 12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>George Shoemaker</u>		14. MOTHER'S MAIDEN NAME <u>Jane Bare</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes give war or dates of service) <u>W.W. # 1</u>		16 SOCIAL SECURITY NO <u>214-05-7688</u>	17 INFORMANT Address <u>Mrs. Mary S. Shoemaker Rt. 1 Mt. Savage, Md.</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> DUE TO <u>CORONARY SCLEROSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>---</u> (c) <u>---</u>			INTERVAL BETWEEN DEATH AND EXAMINATION <u>SUDDEN</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Benedict Skitarelic</u> M.D. EXAMINER'S NAME (Type) <u>BENEDICT SKITARELIC, M.D.</u>		22. DATE SIGNED CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>May 12, 1967</u> Address (Street, city, town, or county) <u>Cumberland, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>5/15/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Restlawn Memorial Gardens</u>	23d. LOCATION (City or Town) (County) (State) <u>LaVale, Allegany, Md.</u>
24. FUNERAL DIRECTOR ADDRESS <u>H. Wayne George Cumberland, Md.</u>		25a. REC'D BY REGISTRAR <u>MAY 18 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

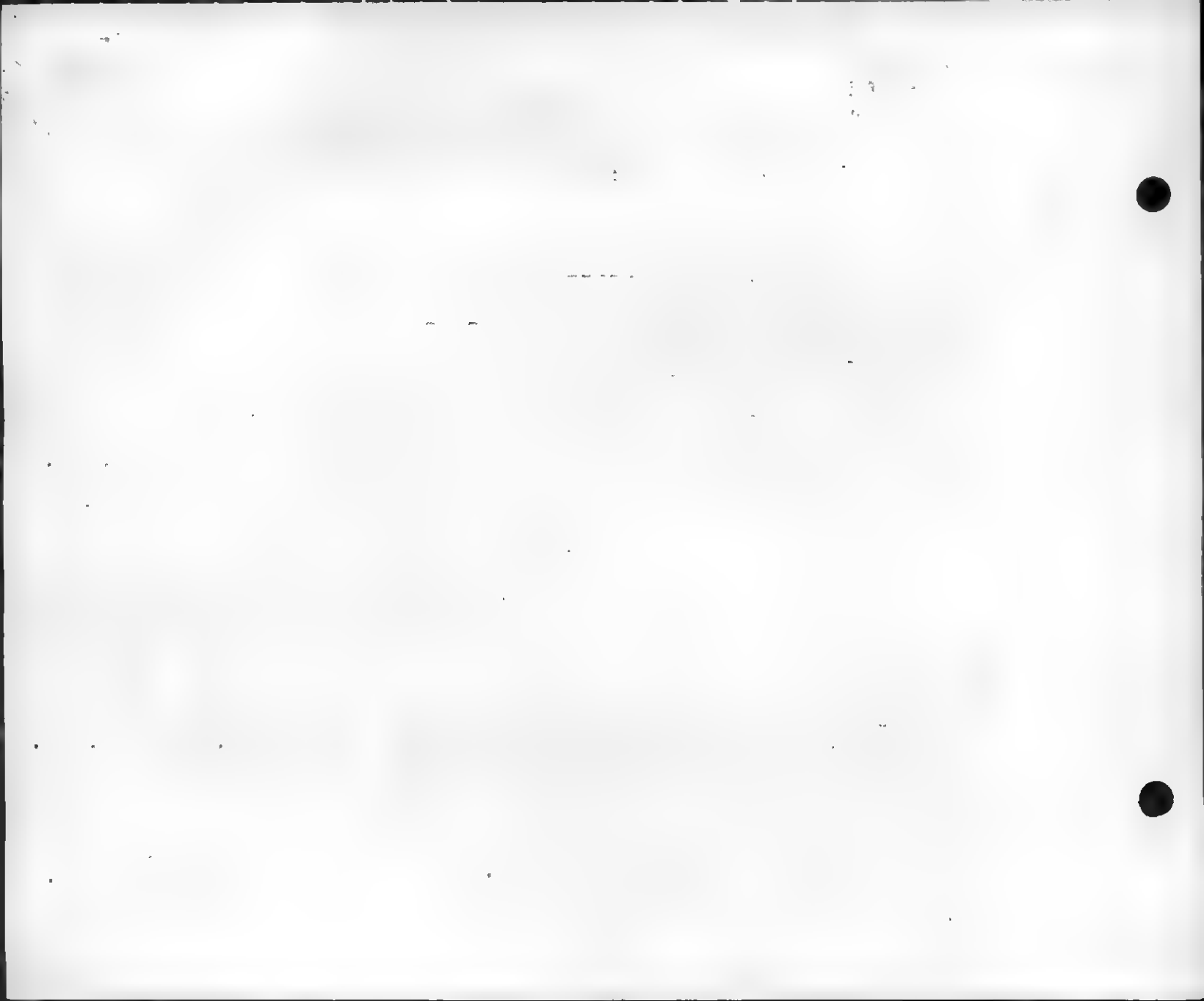
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06067

1057

1 PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	c. LENGTH OF STAY IN 1b 16:30 Hours	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellerslie	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital		d. STREET ADDRESS	
3 NAME OF DECEASED (Type or print) First Middle Last Charles ----- Sisler		4 DATE OF DEATH Month Day Year May 27 1967	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 1-27-1880
9 AGE (In years, last birthday) 87		10 IF UNDER 1 YEAR Months Days Hours Min 11 11 11 11	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Janitor		10b KIND OF BUSINESS OR INDUSTRY School	
11 BIRTHPLACE (State or foreign country) West Virginia		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME William Sisler		14 MOTHER'S MAIDEN NAME Sarah Reynolds	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) (If yes, give war or dates of service) No		16 SOCIAL SECURITY NO 159-12-4626	
17 INFORMANT Memorial Hospital-Cumberland, Md.		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Asphyxiation DUE TO (b) Aspiration of Stomach Contents DUE TO (c) Multiple injuries		INTERVAL BETWEEN ONSET AND DEATH Hours	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fractures of both legs; Fracture of Ribs		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH Pedestrian struck by auto		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year 9:10 p.m. May 26 1967		20d INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route 35		20f (City or town) (County) (State) Ellerslie, Allegany, Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Benedict Skitarelic EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		22. DATE SIGNED May 27, 1967 Address (Street, city, town, or county) Cumberland, Md.	
23a BURIAL, CREMATION, REMOVAL, (Specify) Burial	23b DATE THEREOF May 30, 1967	23c NAME OF CEMETERY OR CREMATORY Hyndman Cemetery	
23d LOCATION (City or town) (County) (State) Hyndman, Bedford Co., Pa.		24. FUNERAL DIRECTOR Harvey N. Zeigler ADDRESS Hyndman, Pa.	
25a REC'D BY REG. STRAR DATE JUN 2 1967		25b REGISTRAR'S SIGNATURE Judge	



1 4
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

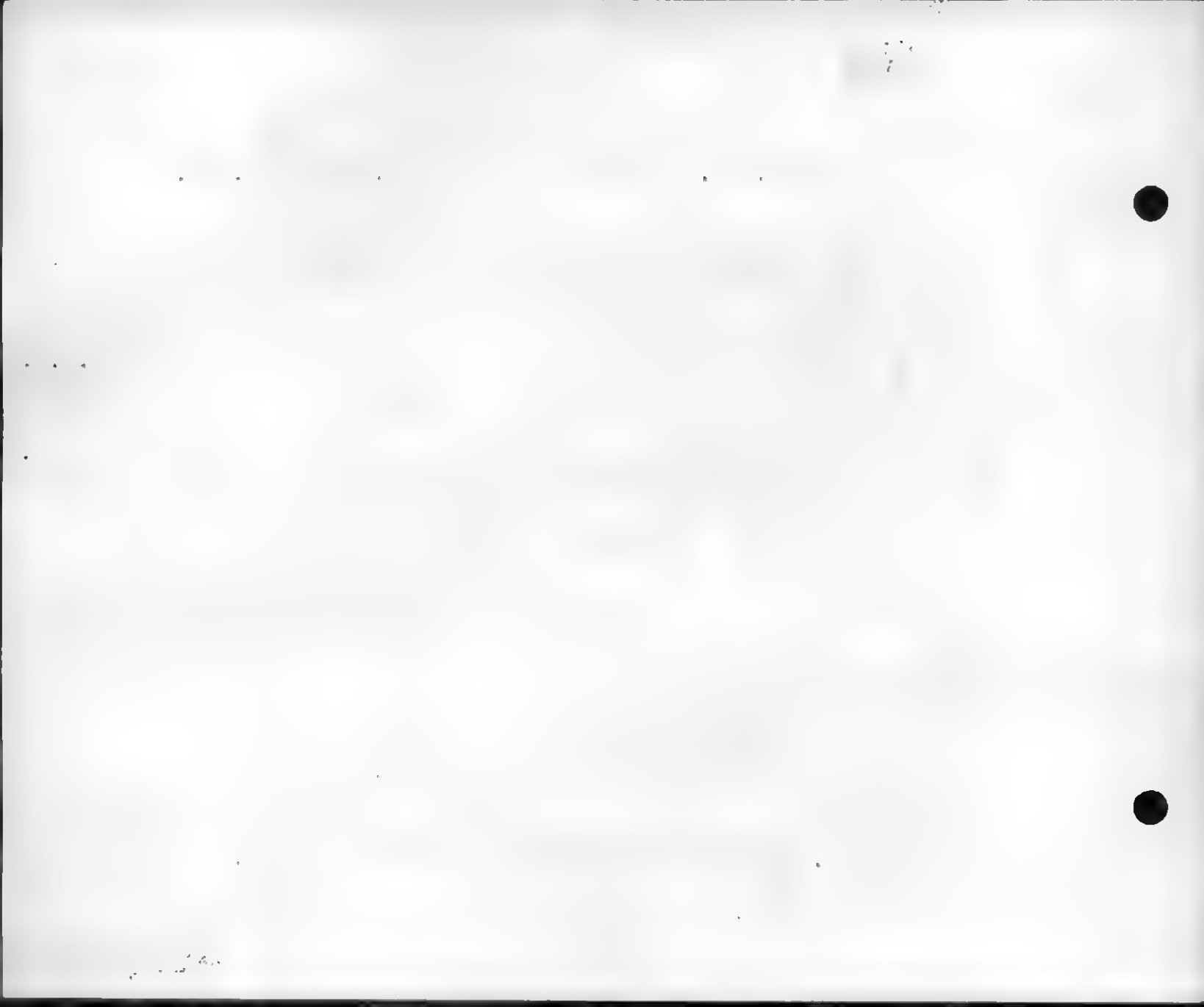
06068

CERTIFICATE OF DEATH

07520

1 PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE W. VIRGINIA b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MD.		c. LENGTH OF STAY in lb 1 DAY	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		e. STREET ADDRESS FT. ASHBY, W. VA.	
3 NAME OF DECEASED (Type or print) First ARLIE Middle R. Last STARKEY		4 DATE OF DEATH Month MAY Day 31 Year 67	
5 SEX FEMALE	6 COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 7-7-19
9. AGE (In years last birthday) 47 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales lady		10b. KIND OF BUSINESS OR INDUSTRY Dept. Store	
11 BIRTHPLACE (County & State, or foreign country) WEST VIRGINIA Perkins		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME UEL RICHARDS		14. MOTHER'S MAIDEN NAME BELLE IOWA SEAL	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO	
17 INFORMANT MEMORIAL HOSPITAL		Address CUMBERLAND, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Metastatic - Squamous Cell Carcinoma 194X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Metastatic Thyroid Carcinoma (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 6 hrs
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Dec 9 1966 , to May 1967 , that (I) (we) last saw the deceased alive on 5/31/67 19, and that death occurred at 8:50A M, from cause and on the date stated above.			
22a. SIGNATURE DR. OVERTON HIMMELWRIGHT		22b. DATE SIGNED 6/2/67	
22c. PHYSICIAN'S NAME (Type) DR. OVERTON HIMMELWRIGHT		22d. ADDRESS CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF June 5, 1967	23c. NAME OF CEMETERY OR CREMATORY Green Lawn Cemetery	23d. LOCATION (City or Town) (County) (State) Clarksburg, W. Va.
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		25a. REC'D BY REGISTRAR DATE JUN 9 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please re-make carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



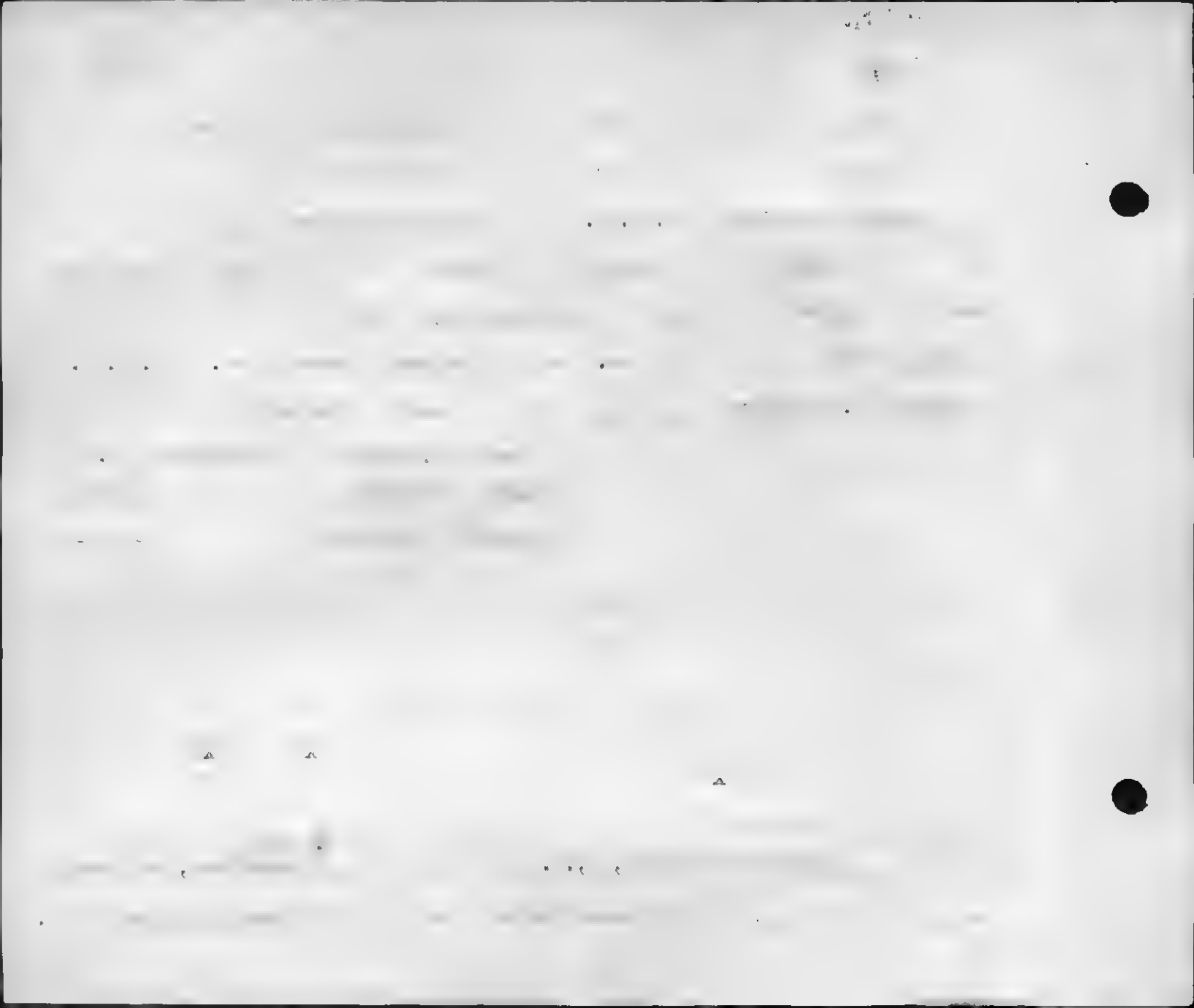
1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any cause is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Allegany</u>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>50 yrs</u>		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		d. STREET ADDRESS <u>717 Gepart Drive</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Edward</u> Middle <u>Malcolm</u> Last <u>Taylor</u>		4. DATE OF DEATH Month <u>May</u> Day <u>17</u> Year <u>1967</u>		5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Month <u>May</u> Day <u>16</u> Year <u>1889</u>		9. AGE (In years last birthday) <u>78</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Boiler Maker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>City Rec. Dept</u>		11. BIRTHPLACE (State or foreign country) <u>Patterson Creek W Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>Edward J. Taylor</u>		14. MOTHER'S MAIDEN NAME <u>Alice Rienhart</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes give year or dates of service) <u> </u>	
16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Edward R. Taylor</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> DUE TO (b) <u>CORONARY SCLEROSIS</u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) <u> </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u> </u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>		20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) <u>Cumberland</u> (County) <u>Allegany</u> (State) <u>Md.</u>		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>May 17, 1967</u>	
ACTUAL SIGNATURE <u>Benedict Skitarelic</u>		EXAMINER'S NAME (Type) <u>BENEDICT SKITARELIC, M.D.</u>		Address (Street, city, town, or county) <u>Cumberland, Maryland</u>		22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 20, 67</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Burial Park</u>		22d. LOCATION (City, town, or county) <u>Cumberland Allegany Md.</u>	
23. FUNERAL DIRECTOR <u>Theresa Ann Horne, 115 Seal St., Cumberland, Md.</u>		24a. RECORDS REGISTRAR'S SIGNATURE <u>May 22 1967</u>		24b. REGISTRAR'S SIGNATURE <u> </u>		24c. DATE <u>May 22 1967</u>		24d. TIME <u> </u>		24e. PLACE <u> </u>		24f. COUNTY <u>Allegany</u>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

1

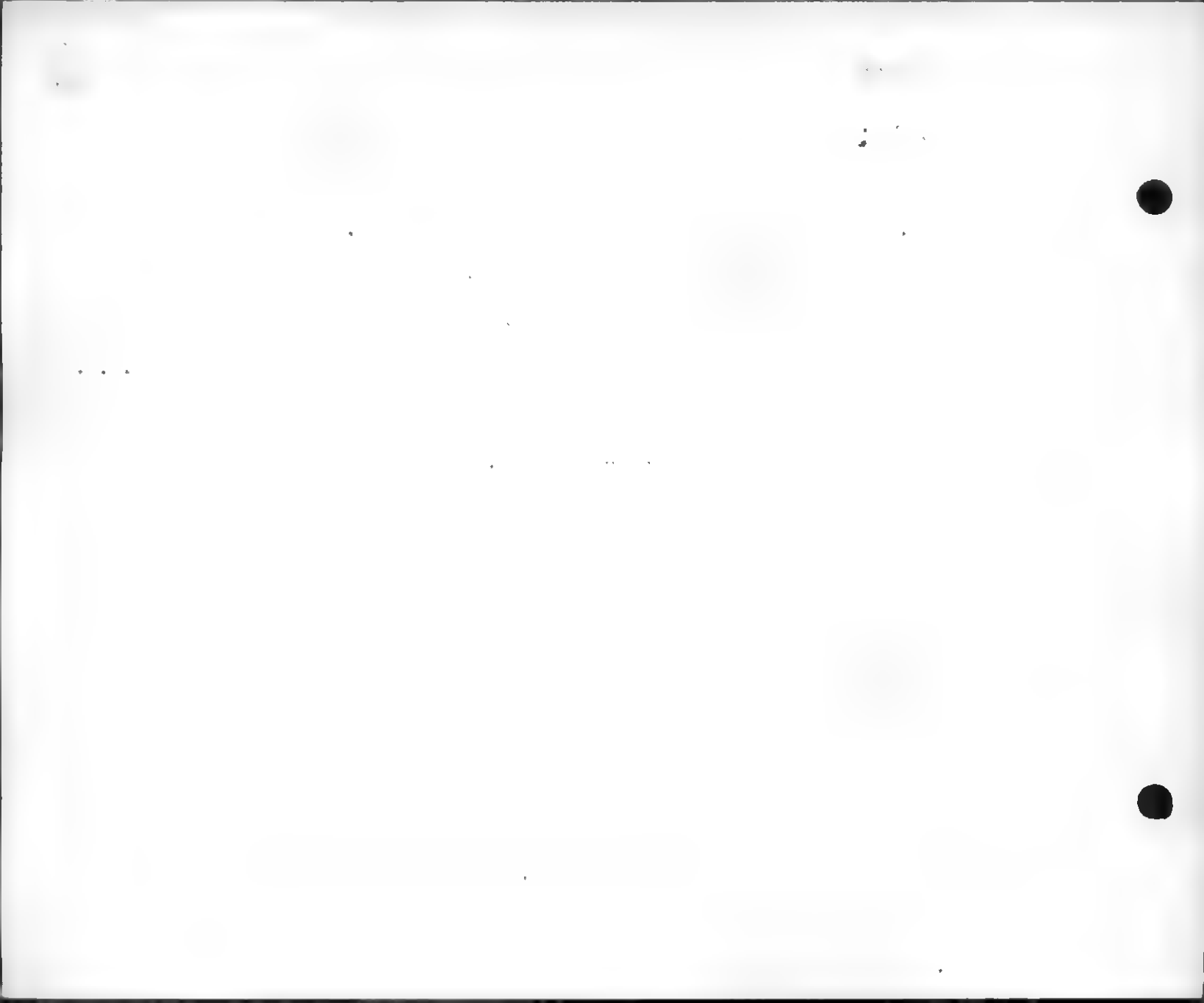
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06070

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00059

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND			2. USUAL RESIDENCE (Where deceased lived, first institution Residence before admission) a. STATE Maryland b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 35 Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 725 N. Mechanic Street			d. STREET ADDRESS 725 N. Mechanic Street		
3. NAME OF DECEASED (Type or print) First Middle Last Ressie LaFayette Teter			4. DATE OF DEATH Month Day Year May 6 19 67		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 5, 1914		9. AGE (in years last birthday) 52 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retail Grocer Employee		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Wymer, West Virginia	
13. FATHER'S NAME Barn Teter			14. MOTHER'S M.A.DEN NAME Esta Lambert		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 214-07-5598		17. INFORMANT Address 124 East Avenue Hagerstown, Md Mrs. Cynthia Teter	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS DUE TO (b) CORONARY SCLEROSIS DUE TO (c) ----- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH SUDDEN
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>Benedict Skitarellic</i> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED	
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> MAY 6, 1967	
		Address (Street, city, town, or county) Cumberland, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5/9/67	23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		23d. LOCATION (City or Town) (County) (State) Cumberland Allegany Maryland	
24. FUNERAL DIRECTOR H. Lee Silcox 404 Decatur St Cumberland, Md		25a. REC'D BY REGISTRAR MAY 9 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
 - Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
 Item #2 info, taken from birth cert.

06071

CERTIFICATE OF DEATH

06060

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Alleg.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG			c. LENGTH OF STAY IN It 1 DAY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MINERS HOSPITAL				d. STREET ADDRESS Rt. 2 Box 306		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) BABY BOY First Middle Last				4. DATE OF DEATH THUSS Month Day Year MAY 23, 19 67			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MAY 22, 1967	
9. AGE (In years last birthday) yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (County & State, or foreign country) FROSTBURG, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME CAROL THUSS			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO. _____		17. INFORMANT CHARLES THUSS, RT. 2, BOX 306, FROSTBURG, MD. Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Premature Birth 1#93 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 26 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 22, 1967 , to May 23, 1967 , that (I) (we) lost the deceased alive on May 23, 1967 , and that death occurred at 2 P. M. from causes and on the date stated above.							
22a. SIGNATURE John B. Davis, M.D.				22b. DATES GNE 5/26/67		22c. PHYSICIAN'S NAME (Type) JOHN B. DAVIS, M. D.	
22d. ADDRESS 2 BROADWAY, FROSTBURG, MD.				22e. REC'D BY REGISTRAR MAY 29 1967			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE THEREOF MAY 24 '67		23c. NAME OF CEMETERY OR CREMATORY BIERTOWN CEMETERY	
23d. LOCATION (City or Town) (County) (State) RAWLINGS, MD.				25b. REGISTRAR'S SIGNATURE Charles Judge			
24. FUNERAL DIRECTOR J. R. DURST, S.R., FROSTBURG, MD.				25a. REGISTRAR'S SIGNATURE Charles Judge			

1 DAY

MAY 22, 1967

111 THURSDAY, MAY 24, 1967

CAROL THOMAS

HT.

U.S.A.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

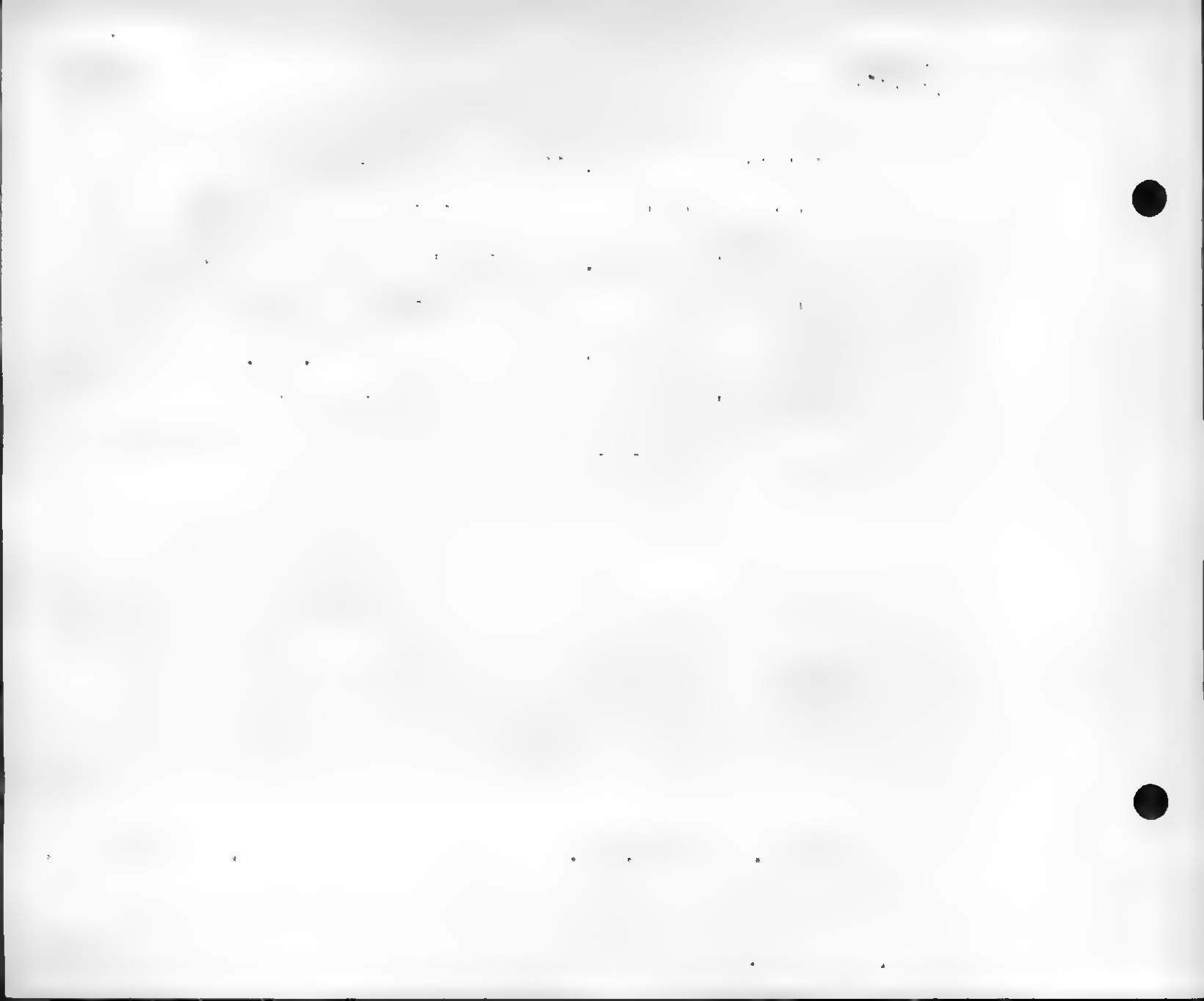
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06072

06061

1 PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 1 DAY 16 HR	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		d. STREET ADDRESS 511 CITY VIEW TERRACE	
3. NAME OF DECEASED (Type or print) First DARWIN Middle D. Last TREXLER		4. DATE OF DEATH Month MAY Day 20 Year 1967	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1901 9-14-1901
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Locomotive Engineer		10b. KIND OF BUSINESS OR INDUSTRY RETIRED	9. AGE (In years lost birthday) 65 yrs
11. BIRTHPLACE (County & State, or foreign country) W. VA.		12. C. T. ZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME GRANT TREXLER		14. MOTHER'S MAIDEN NAME ALICE WINDELL	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 705-10-8470	
17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Cardiac Failure 4/2/1 DUE TO (b) Myocardial Infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) Coronary atherosclerosis		INTERVAL BETWEEN ONSET AND DEATH 3 min. 5 yr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from MAY 18 , 19 67 , to MAY 20 , 19 67 that (I) (we) last saw the deceased alive on MAY 20 , 19 67 , and that death occurred at 5:30 AM from causes and on the date stated above			
22a. SIGNATURE Clay E. Durrett		22b. DATE SIGNED 5/20/67	
22c. PHYSICIAN'S NAME (Type) CLAY E. DURRETT, MD.		22d. ADDRESS 236 VIRGINIA AVE., CUMBERLAND, MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF May 23, 1967	23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park	23d. LOCATION (City or Town) (County) (State) Near Cumberland Alleg Md.
24. FUNERAL DIRECTOR John J. Nafer, Jr.		25a. REG'D. BY REGISTRAR MAY 24 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge		26. ADDRESS 230 Balto Ave. Cumberland Md	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal and in any event within 72 hours after death.

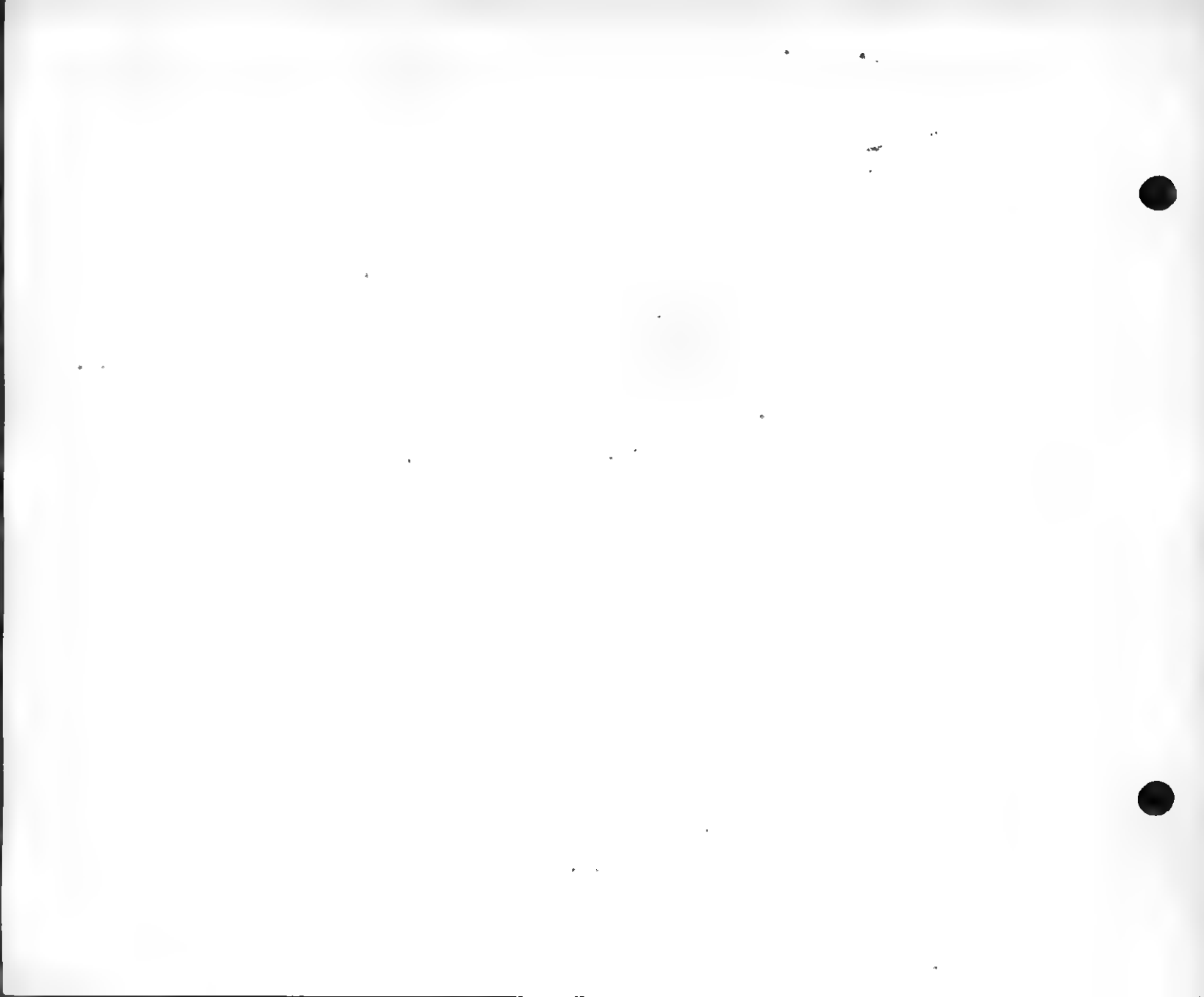
VR A15ME (5)
6M 1/66

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06073

06062

1 PLACE OF DEATH a. COUNTY Allegany MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN TB 73 Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital				d. STREET ADDRESS 521 Lowell Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Clarence Middle Denzil Last Valentine, Sr.				4. DATE OF DEATH Month May Day 10 Year 19 67			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 20- 1893		9. AGE (In years last birthday) 73 yrs	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life) Retired clerk Trial Magistrate Court		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Cumberland Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George P. Valentine				14. MOTHER'S MAIDEN NAME Mary Jane McVicker			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 217-28-9438		17. INFORMANT Clarence D. Valentine, Jr		Address 1914 Bedford St Cumberland, Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac Failure DUE TO (b) Pulmonary Fibrosis; Emphysema; Marked DUE TO (c) lost.							INTERVAL BETWEEN ONSET AND DEATH Days --
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Benedict Skitarelic M.D. EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.				22. DATE SIGNED DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> May 10, 1967 Address (Street, city, town, or county) Cumberland, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/13/67		23c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery		23d. LOCATION (City or Town) (County) (State) Cumberland Allegany Maryland	
24. FUNERAL DIRECTOR H. Lee Silcox Cumberland Maryland 21502				25a. REC'D BY REGISTRAR MAY 11 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
M

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
06074 CERTIFICATE OF DEATH JCC63

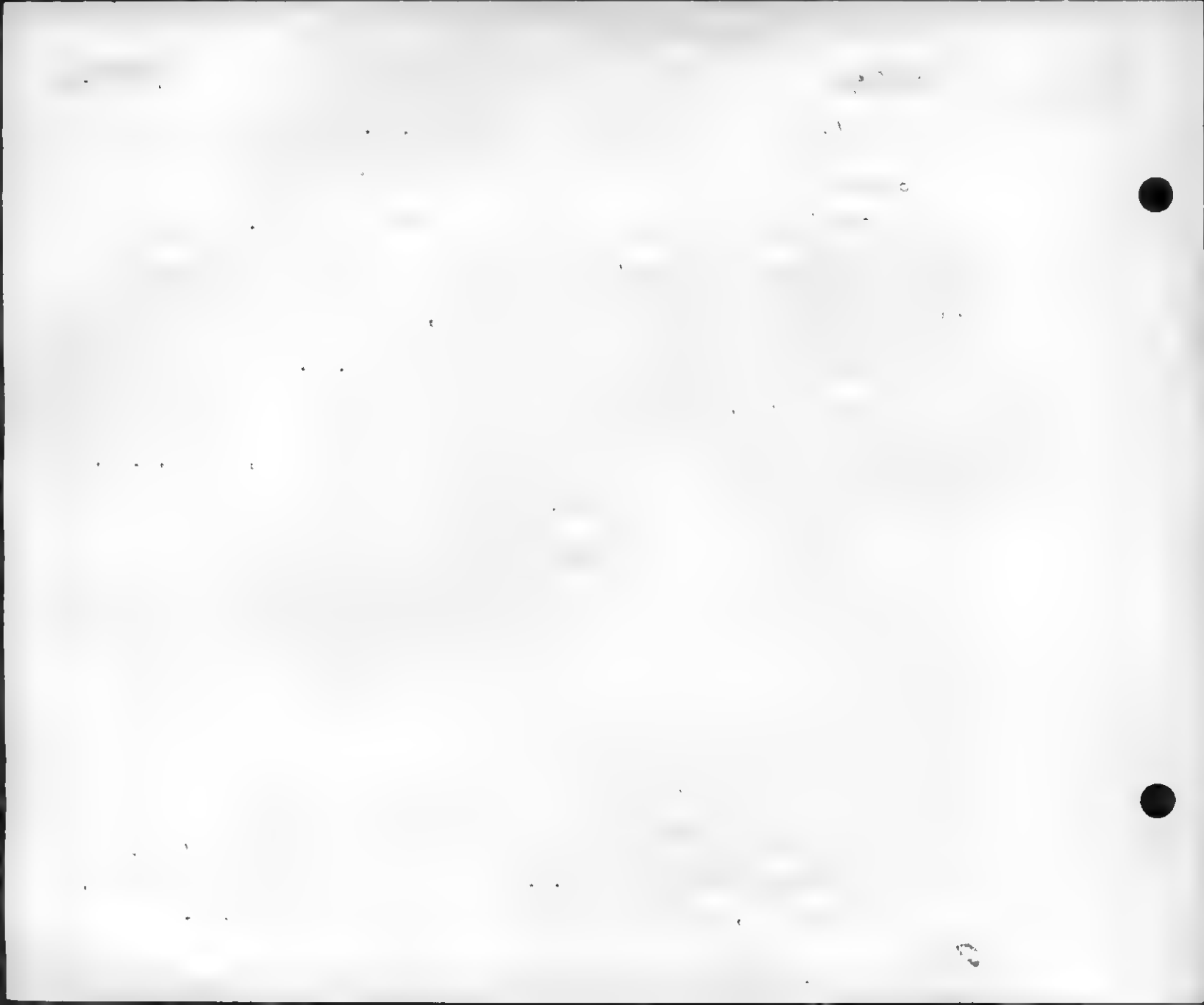
1. PLACE OF DEATH a. COUNTY ALLEGANY		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MD.		c. LENGTH OF STAY IN 1b 40 HRS.		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		b. COUNTY ALLEGANY		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND		d. STREET ADDRESS 418 GRAND AVE.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) EDITH		First		Middle M.		Last VAN METER		4. DATE OF DEATH Month MAY		Day 11		Year 1967							
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/25/21		9. AGE (in years last birthday) 46 yrs.		IF UNDER 1 YEAR Months 		IF UNDER 24 HRS. Days 		Hours 					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HWF				10b. KIND OF BUSINESS OR INDUSTRY 				11. BIRTHPLACE (County & State, or foreign country) GARRETT, MARYLAND				12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME JONAS MORELAND								14. MOTHER'S MAIDEN NAME MARY DAVIS											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO				16. SOCIAL SECURITY NO. 216-34-5195				17. INFORMANT HOSP. RECORD				Address SACRED HEART HOSPITAL							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) STATUS ASTHMATICUS DUE TO (b) BRONCHIAL ASTHMA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) DUE TO (c) 												INTERVAL BETWEEN ONSET AND DEATH 3 DAYS 15 YEARS							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from 5 - 9, 1967 , to 5 - 11, 1967 , that (I) (we) last saw the deceased alive on 5 - 11, 1967 , and that death occurred at 3 P.M. , from the causes and on the date stated above.																			
22a. SIGNATURE <i>Ralph W. Ballin</i>												22b. DATE SIGNED 5-11-67							
22c. PHYSICIAN'S NAME (Type) RALPH W. BALLIN, M.D.												22d. ADDRESS 62 GREENE ST. CUMBERLAND, MD. 21502							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 5/14/67				23c. NAME OF CEMETERY OR CREMATORY Maysville				23d. LOCATION (City, town or county) (State) Maysville W. Va.							
24. FUNERAL DIRECTOR <i>E. J. Bural</i>								ADDRESS Westernport, Md.				25a. REC'D BY REGISTRAR MAY 18 1967				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

<div>Item 1: Film 389 5-25-67 MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>06075 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 05064</div>											
1 PLACE OF DEATH a COUNTY Allegany MARYLAND						2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE W. Va. b COUNTY Mineral					
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) McCaule				c LENGTH OF STAY IN 1b		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Keyser					
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Memorial Bridge						d STREET ADDRESS 537 Newton St.				e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last Robert Paul Viney						4 DATE OF DEATH Month Day Year May 19th, 1967					
5 SEX Male		6 COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8 DATE OF BIRTH May 2, 1923		9 AGE (In years last birthday) yrs 44		10 IF UNDER 1 YEAR Months Days Hours M.n.	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) Hampshire, W. Va.				12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME Albert Viney						14. MOTHER'S MAIDEN NAME Grace Willis					
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16 SOCIAL SECURITY NO		17. INFORMANT Kennell Viney, Keyser, W. Va. Address					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Asphyxiation 3000 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) Aspiration of Stomach Contents DUE TO (c) Acute alcoholism										INTERVAL BETWEEN ONSET AND DEATH Minutes	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)		20f (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Benedict Skitarelic M.D. EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.						22. DATE SIGNED CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> May 19, 1967 Address (Street, city, town, or county) Cumberland, Md.					
23a BURIAL CREMATION, REMOVAL (Specify) Burial				23b DATE THEREOF May 23, 1967		23c NAME OF CEMETERY OR CREMATORY Queens Point Cemetery				23d LOCATION (City or Town) (County) (State) Keyser, W. Va.	
24 FUNERAL DIRECTOR Allen M. Rotruck, Keyser, W. Va. ADDRESS						25a RECD BY REGISTRAR DATE MAY 22 1967		25b REGISTRAR'S SIGNATURE Charles Judge			



FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If city delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

36076

36065

1 PLACE OF DEATH a. COUNTY Allegany MARYLAND				2 USUAL RESIDENCE (Where deceased lived, first location. Residence before admission) a. STATE Maryland b. COUNTY Garrett			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg,		c. LENGTH OF STAY IN 1b DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Grantsville			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Miners				d. STREET ADDRESS Route 40		e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Lewis First Middle Last Louis Alfred Walls				4. DATE OF DEATH Month May Day 1 Year 1967			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/15/1915	9. AGE (In years last birthday) 51 yrs	IF UNDER 1 YEAR Months 5 Days 15 Hours 52 Min 52		IF UNDER 24 HRS Hours 52 Min 52
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lineman		10b. KIND OF BUSINESS OR INDUSTRY Potomac Edison Co., Grantsville, Md.		11. BIRTHPLACE (State or foreign country) Grantsville, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Walls				14. MOTHER'S MAIDEN NAME Sally Butler			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or Unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO 01-1-2001		17. INFORMANT Address Mrs. Sally Walls, Grantsville, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY 9148 IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Electrocution DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH Sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18) Lineman working on 12000 volt line					
20c. TIME OF INJURY Month, Day, year 2:45 p.m. May 1 1967		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) Carlos,		20f. (City or town) (County) (State) Carlos, Garrett, Maryland	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Benedict Skitarelic		EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED May 1, 1967	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/4/67		23c. NAME OF CEMETERY OR CREMATORY Oak Grove Menn. Cem.		23d. LOCATION (City or town) (County) (State) Grantsville, Md.	
24. FUNERAL DIRECTOR Ruth Newman		ADDRESS Grantsville, Md.		25a. REC'D BY REGISTRAR MAY 5 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06077

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

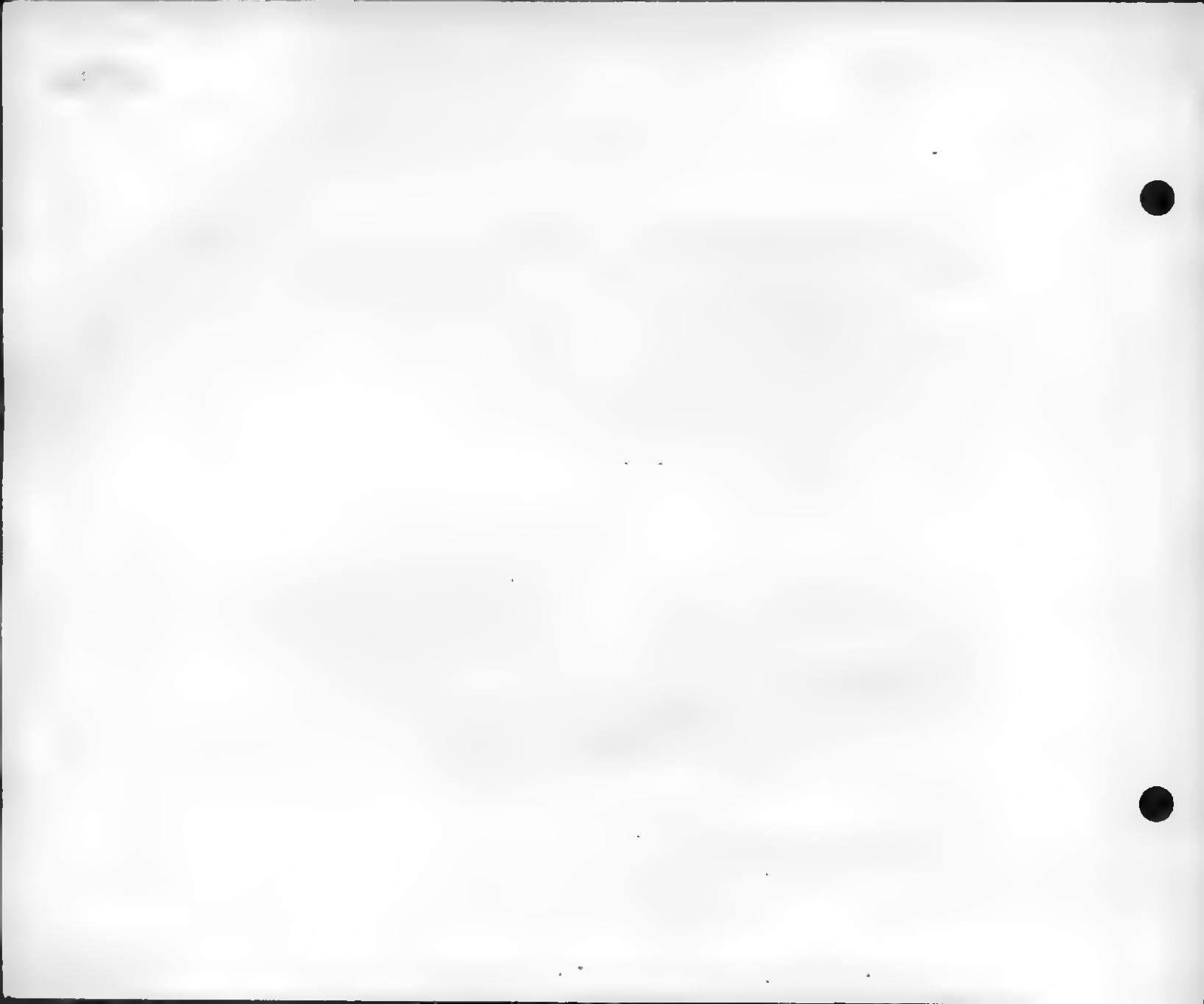
06066

FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Allegany MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE Maryland b COUNTY Allegany			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c LENGTH OF STAY IN 1b Cumberland			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Hospital				d STREET ADDRESS Route 4, Oldtown Road			
3 NAME OF DECEASED (Type or print) First Middle Last Rhoda Rosetta Ward				4 DATE OF DEATH Month Day Year May 1 19 67			
5. SEX Female	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Dec. 5, 1930	9 AGE (In years last birthday) 36 yrs	IF UNDER 1 YEAR Months Days Hours Min		F UNDER 24 HRS Hours Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? U S A
13 FATHER'S NAME Jacob Ritchie				14 MOTHER'S MAIDEN NAME Ada Dove			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO 220-30-7960		17 INFORMANT Address Daniel Ward, Box 283, Route 4, Cumberland, Md			
18 CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE DUE TO (b) Rupture of Congenital Aneurysm of anterior cerebral artery OUE TO (c) 2 Hours						INTERVAL BETWEEN ONSET AND DEATH 2 Hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c TIME OF INJURY Month, Day, Year Hour a.m. pm 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Benedict Skitarelic M.D. EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> May 1, 1967 Address (Street, city, town, or county) XXX Cumberland, Md.			
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF May 4, 1967		23c NAME OF CEMETERY OR CREMATORY Sunset Memorial Gardens		23d LOCATION (City or Town) (County) (State) Near Cumberland Alleg Md	
24. FUNERAL DIRECTOR John J. Hafert Jr.				25a REC'D BY REGISTRAR MAY 5 1967		25b REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please rejoin pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06078

CERTIFICATE OF DEATH

06067

1 PLACE OF DEATH a COUNTY ALLEGANY MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			c LENGTH OF STAY in lb 50 YEARS			c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 31 RIDGEWAY TERRACE				d. STREET ADDRESS 31 RIDGEWAY TERRACE		e RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First GEORGE Middle W. Last WEBER				4. DATE OF DEATH Month MAY Day 27 Year 1967			
5. SEX MALE		6 COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH JULY 9, 1882	
9. AGE (In years lost birthday) 84 yrs		IF UNDER 1 YEAR Months 0 Days 0		IF UNDER 24 HRS Hours 0 Min 0			
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER				10b KIND OF BUSINESS OR INDUSTRY SELF-EMP.		11 BIRTHPLACE (County & State, or foreign country) PATTERSONS CREEK, W. VA.	
12 CITIZEN OF WHAT COUNTRY? USA							
13 FATHER'S NAME JOHN WEBER				14. MOTHER'S MAIDEN NAME GERTRUDE GLEICHMAN			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 214 07 1206		17. INFORMANT EFFIE E. WEBER Address CUMBERLAND, MD.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Myocardial infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis general DUE TO (c) Coronary atherosclerosis				INTERVAL BETWEEN ONSET AND DEATH 1 year			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic emphysema, pulmonary				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 6		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from May 17, 1967 to May 27, 1967 , that (I) (we) last saw the deceased alive on May 17, 1967 , and that death occurred at 10:11 M, from causes and on the date stated above.							
22a SIGNATURE David T. Rees				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b DATE SIGNED MAY 29, 1967	
22c. PHYSICIAN'S NAME (Type) DAVID T. REES, M.D.				22d. ADDRESS 712 MONTGOMERY AVE. CUMBERLAND, MD.			
23a BURIAL CREMATION, REMOVAL (Specify) BURIAL		23b DATE THEREOF MAY 29, 1967		23c. NAME OF CEMETERY OR CREMATORY ST. LUKES CEMETERY		23d LOCATION (City or Town) (County) (State) CUMBERLAND, MD.	
24. FUNERAL DIRECTOR BYRON KIGHT				ADDRESS CUMBERLAND, MD.		25a. REC'D BY REGISTRAR JUN 1 1967	
				25b. REGISTRAR'S SIGNATURE Charles Judge			



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06073

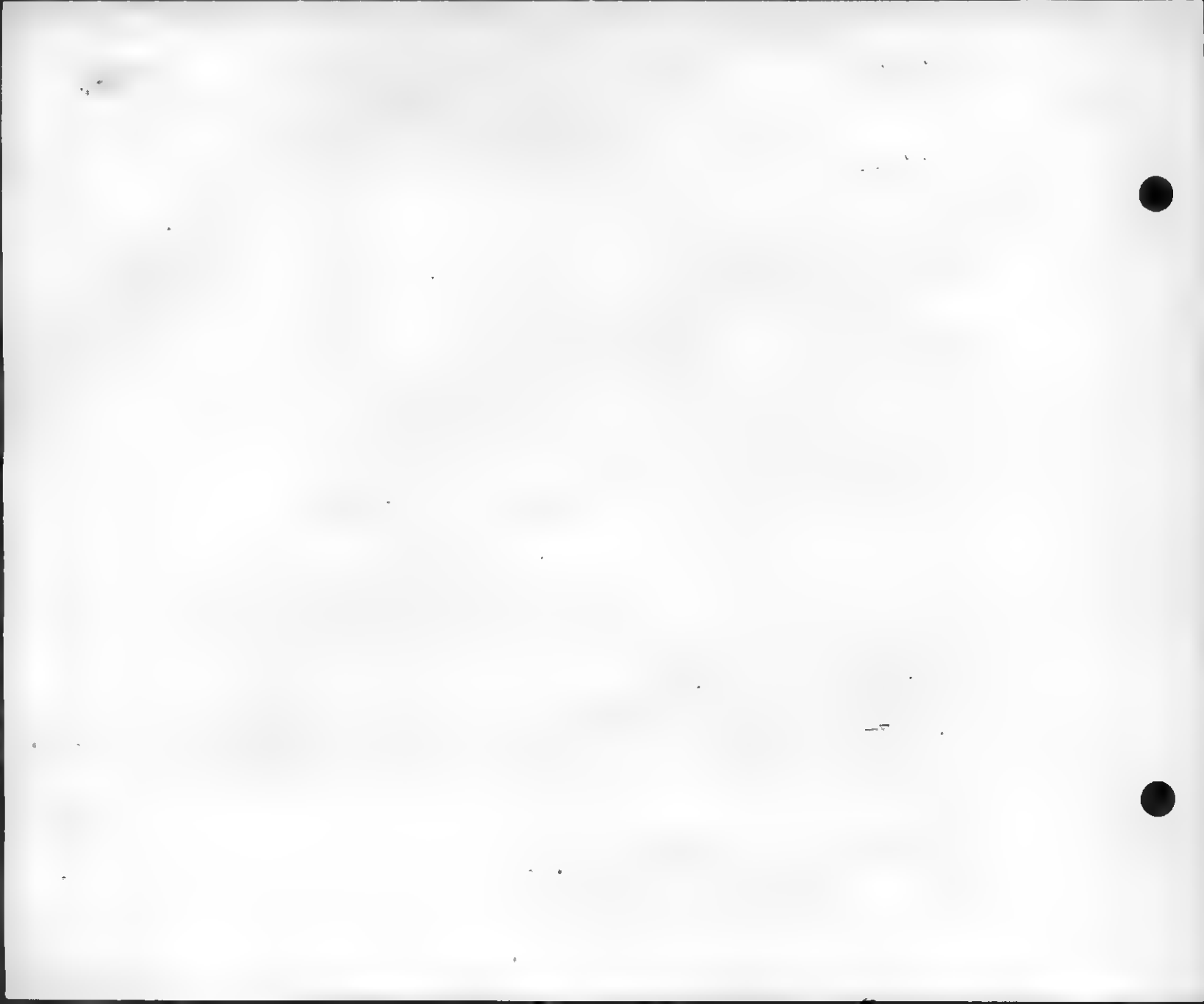
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

100268

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PWG. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland			c. LENGTH OF STAY IN 1b 24 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland 01-1		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital				d. STREET ADDRESS 129 West Second St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First George Middle Edward Last White				4. DATE OF DEATH Month May Day 12 Year 19 67			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 14, 1942		9. AGE (In years last birthday) 24 yrs	F UNDER 1 YEAR Months 24 Days 0 Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attendant		10b. KIND OF BUSINESS OR INDUSTRY Fire Co. (Vol.)		11. BIRTHPLACE (State or foreign country) Los Angeles, Calif.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Marshall White				14. MOTHER'S MAIDEN NAME Gladys Newman			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes-Marines 61-65		16. SOCIAL SECURITY NO		17. INFORMANT Address Mrs. Gladys White, Cumberland, Md.			
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) EPIDURAL HEMATOMA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) SKULL FRACTURE DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 2 Days	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Driver of Motorcycle in Collision with Car.					
20c. TIME OF INJURY Month, Day, Year 9:30 p.m. May 10 67		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Greene Street		20f. (City or town) (County) (State) Cumberland, Allegany, Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Benedict Skitarelic		EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED May 12, 1967 Address (Street, city, town, or county) Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 14, 1967		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		23d. LOCATION (City or Town) (County) (State) Cumberland, Md. Allegany	
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.				25a. REC'D BY REGISTRAR MAY 17 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
 Items #^k & 9 Film 3-11-67

36080

CERTIFICATE OF DEATH

06059

1. PLACE OF DEATH a COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE MARYLAND b COUNTY ALLEGANY			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c LENGTH OF STAY in 1b 3MO-1WK-3½DA.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL				e STREET ADDRESS 534 A STREET			
3. NAME OF DECEASED (Type or print) LESTER L. WILKINSON				4. DATE OF DEATH Month MAY Day 29 Year 1967			
5 SEX MALE	6 COLOR OR RACE WHITE	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B DATE OF BIRTH 1891		9 AGE (In years last birthday) 76 yrs	IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, when retired) RETIRED		10b. KIND OF BUSINESS OR INDUSTRY Wholesale Dealer		11 BIRTHPLACE (Country & State, or foreign country) CUMBERLAND, MARYLAND		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOSEPH WILKINSON				14. MOTHER'S MAIDEN NAME HATTIE ROWLINGS			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO —		17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Terminal Hepatic failure 157X DUE TO (b) Hypertrophic cirrhosis Liver DUE TO (c) Colicoma tonsils with melanotic line						INTERVAL BETWEEN ONSET AND DEATH 100 days 1 year + 1 year	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cholecystectomy as exploratory Common Bile duct 29 Sept 67						19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)		21 I certify that (I) (this hospital) attended the deceased from 1 gm , 1950 to 29 May , 1967, that (I) (we) last saw the deceased alive on 28 May , 1967, and that death occurred at 5:45 AM , from causes and on the date stated above.			
22a SIGNATURE W. Alfred Van Ormer, M.D.				22b DATE SIGNED 29 May 67		22c PHYSICIAN'S NAME (Type) DR. W. A. VAN ORMER	
22d ADDRESS 122 SO. CENTRE ST, CUMBERLAND, MD.				23a BURIAL, CREMATION, or REMOVAL (Specify) Burial			
23b DATE THEREOF 5/31/67		23c NAME OF CEMETERY OR CREMATORY Hellcrest Burial Pl.		23d LOCATION (City or town) (County) (State) Cumberland MD.		23e ADDRESS Lewis Stein Inc. Cumb. MD.	
24. FUNERAL DIRECTOR		25a REC'D BY REGISTRAR DATE JUN 1 1967		25b REGISTRAR'S SIGNATURE W. A. Van Ormer			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE HEALTH DEPT.

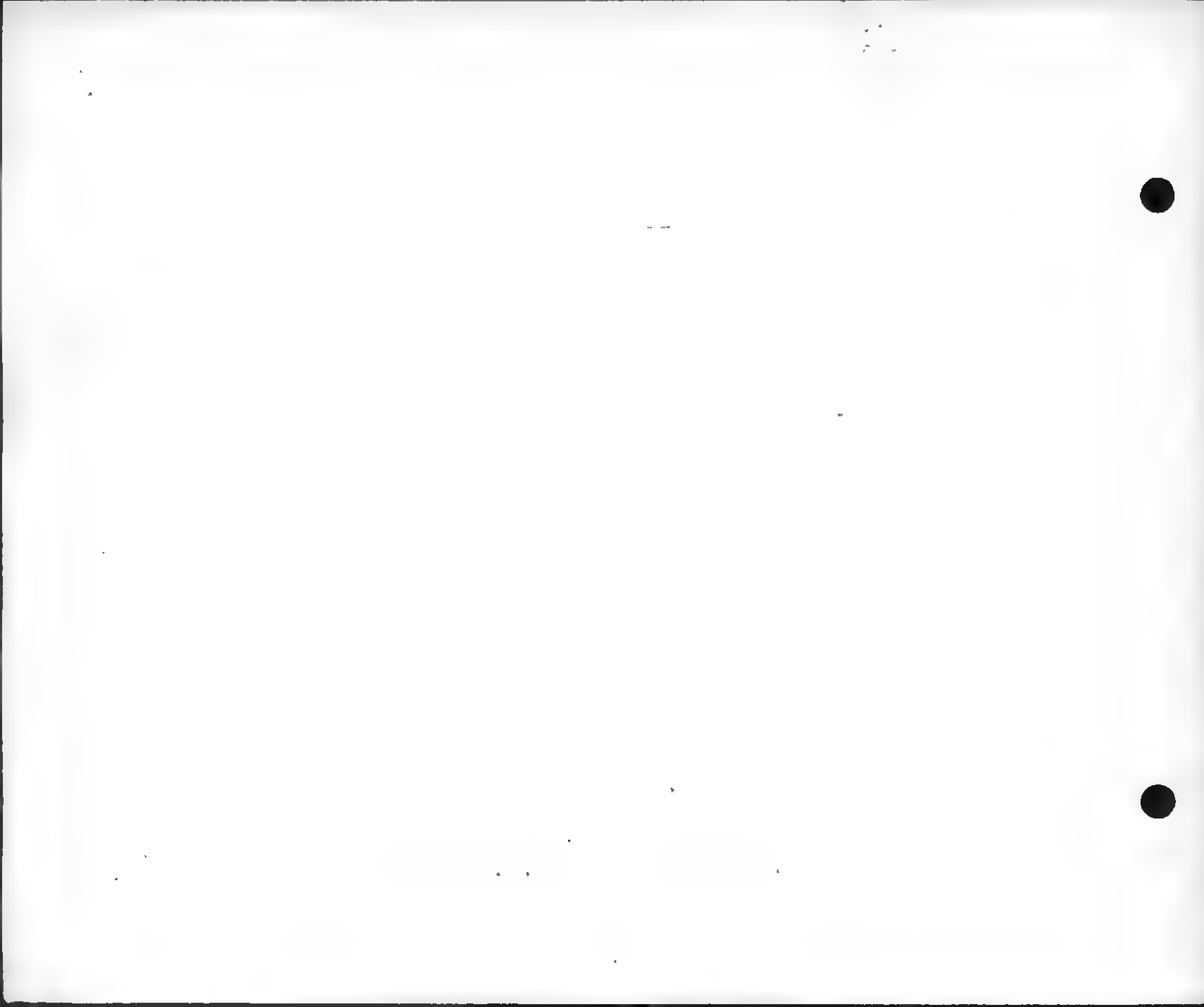
06081

06070

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pen on form 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 40 YEARS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital--DOA		e. STREET ADDRESS 12 QUEEN CITY PAVEMENT	
3. NAME OF DECEASED (Type or print) First Middle Last THEODORE B. WILLIAMS		4. DATE OF DEATH Month Day Year MAY 26 1967	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG. 31, 1903
9. AGE (In years last birthday) yrs 63		10. IF UNDER 1 YEAR Months Days Hours Mins 1967	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY RAILROAD	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME GEORGE WILLIAMS		14. MOTHER'S MAIDEN NAME VIOLA PORTER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO UNKNOWN	
17. INFORMANT JAMES E. WILLIAMS		Address CUMBERLAND, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CORONARY OCCLUSION DUE TO CORONARY SCLEROSIS Conditions if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) -- (c) --			INTERVAL BETWEEN ONSET AND DEATH SUDDEN
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspect an <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion an death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Benedict Skitarelic</i> M.D. EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		22. DATE SIGNED CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> May 26, 1967 Address (Street, city, town or county) Cumberland, Md.	
23a. BURIAL, CREMATION REMOVAL (Specify) BURIAL	23b. DATE THEREOF MAY 29, 1967	23c. NAME OF CEMETERY OR CREMATORY HILLCREST BURIAL PARK	23d. LOCATION (City or Town) (County) (State) CUMBERLAND, MD.
24. FUNERAL DIRECTOR BYRON KIGHT		25. REC'D BY REGISTRAR DATE JUN 1 1967	
ADDRESS CUMBERLAND, MD.		26. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06082

06071

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND , b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MD.		c. LENGTH OF STAY IN 1b 9 HOURS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MIDLAND			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SACRED HEART HOSPITAL				d. STREET ADDRESS MIDLAND, MD. 21542		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ROBERT Middle W. Last WILSON				4. DATE OF DEATH Month MAY Day 5 Year 1967			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-20-35	
9. AGE (In years last birthday) 32 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CONTRACTING WORK		10b. KIND OF BUSINESS OR INDUSTRY MARSH CONTRACTING		11. BIRTHPLACE (County & State, or foreign country) MIDLAND, MD. 21542	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME ROBERT WILSON			
14. MOTHER'S MAIDEN NAME MARTHA ANN WINTERS				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES			
16. SOCIAL SECURITY NO.				17. INFORMANT HOSP. RECORD			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema 410X DUE TO (b) Mitral Stenosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Rheumatic Heart Disease				INTERVAL BETWEEN ONSET AND DEATH —			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5/5, 1967 , to 5/5, 1967 , that (I) (we) last saw the deceased alive on 5/5, 1967 , and that death occurred at 12:07 PM , from the causes and on the date stated above.							
22a. SIGNATURE [Signature]				22b. DATE SIGNED 5/5/67		22c. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22d. PHYSICIAN'S NAME (Type) J. A. Pagan, M.D.				22e. ADDRESS [Signature]			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/8/67		23c. NAME OF CEMETERY OR CREMATORY Memorial Park		23d. LOCATION (City, town or county) (State) Frostburg A. Md	
24. FUNERAL DIRECTOR George Eichhorn				25a. REC'D BY REGISTRAR MAY 9 1967		25b. REGISTRAR'S SIGNATURE [Signature]	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06083

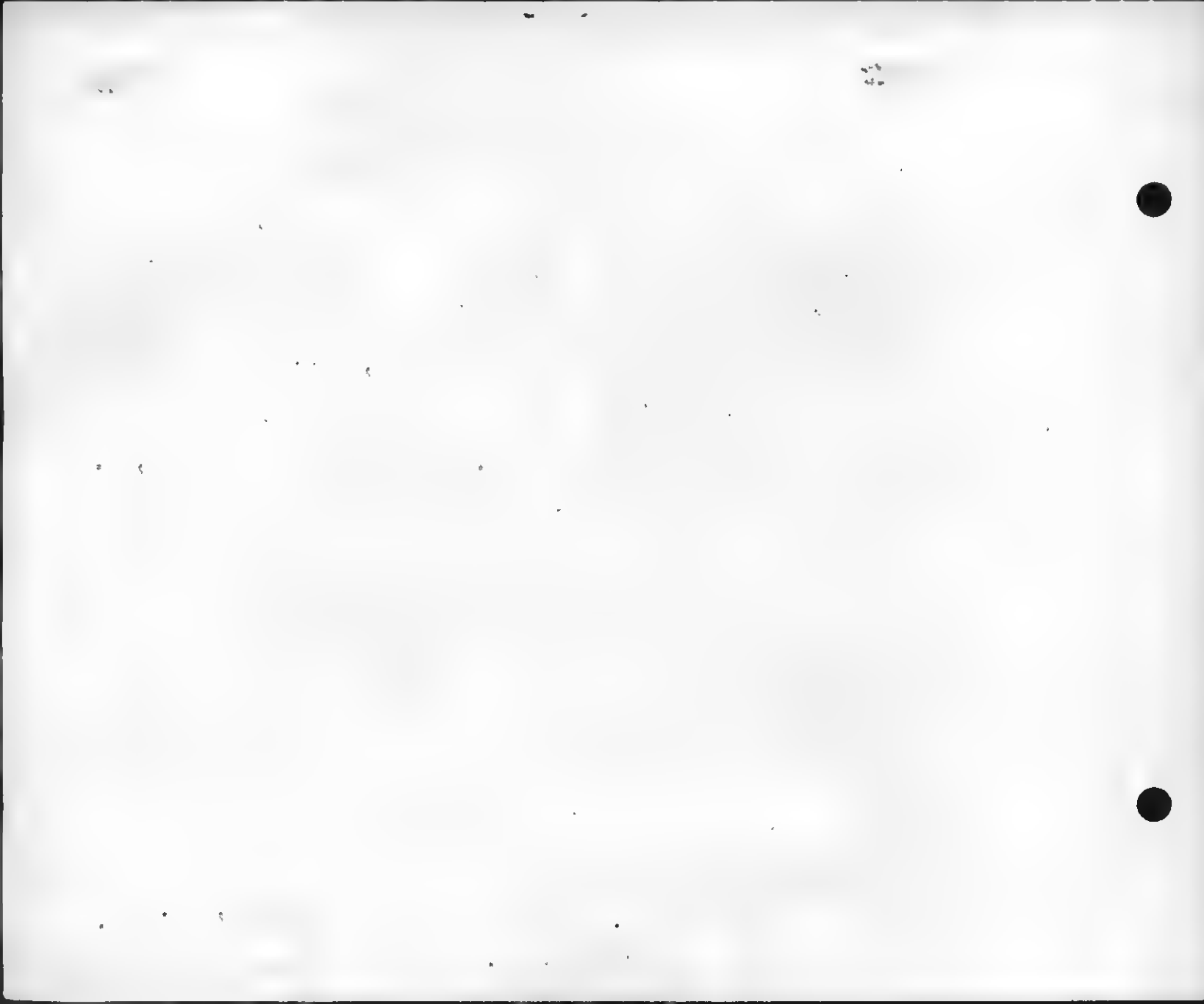
CERTIFICATE OF DEATH

06072

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Midland		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Church Street		e. STREET ADDRESS Church Street	
3. NAME OF DECEASED (Type or print) ROSE F. WINNER		4. DATE OF DEATH 5/12/1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/13/1895
9. AGE (In years last birthday) 71		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State or foreign country) Avilton, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Isador Garlitz		14. MOTHER'S MAIDEN NAME Elizabeth McKenzie	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None	
17. INFORMANT Mrs. Lena Stephens		Address Midland, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Coronary Occlusion DUE TO (b) Generalized Arteriosclerosis DUE TO (c) years		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1954 to May 12, 1967 , that (I) (we) last saw the deceased alive on May 9, 1967 , and that death occurred at 2P M, from causes and on the date stated above.			
22a. SIGNATURE L.R. Miles, Jr. M.D.		22b. DATE SIGNED 5.13.67	
22c. PHYSICIAN'S NAME (Type) L.R. MILES, JR. M.D.		22d. ADDRESS LONA CONING MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/16/1967	
23c. NAME OF CEMETERY OR CREMATORY St. Anns Cemetery		23d. LOCATION (City or Town) (County) (State) Avilton, Md. G.	
24. FUNERAL DIRECTOR George Eichhorn		25a. REC'D BY REGISTRAR MAY 15 1967	
Address Lonaconing, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2. should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

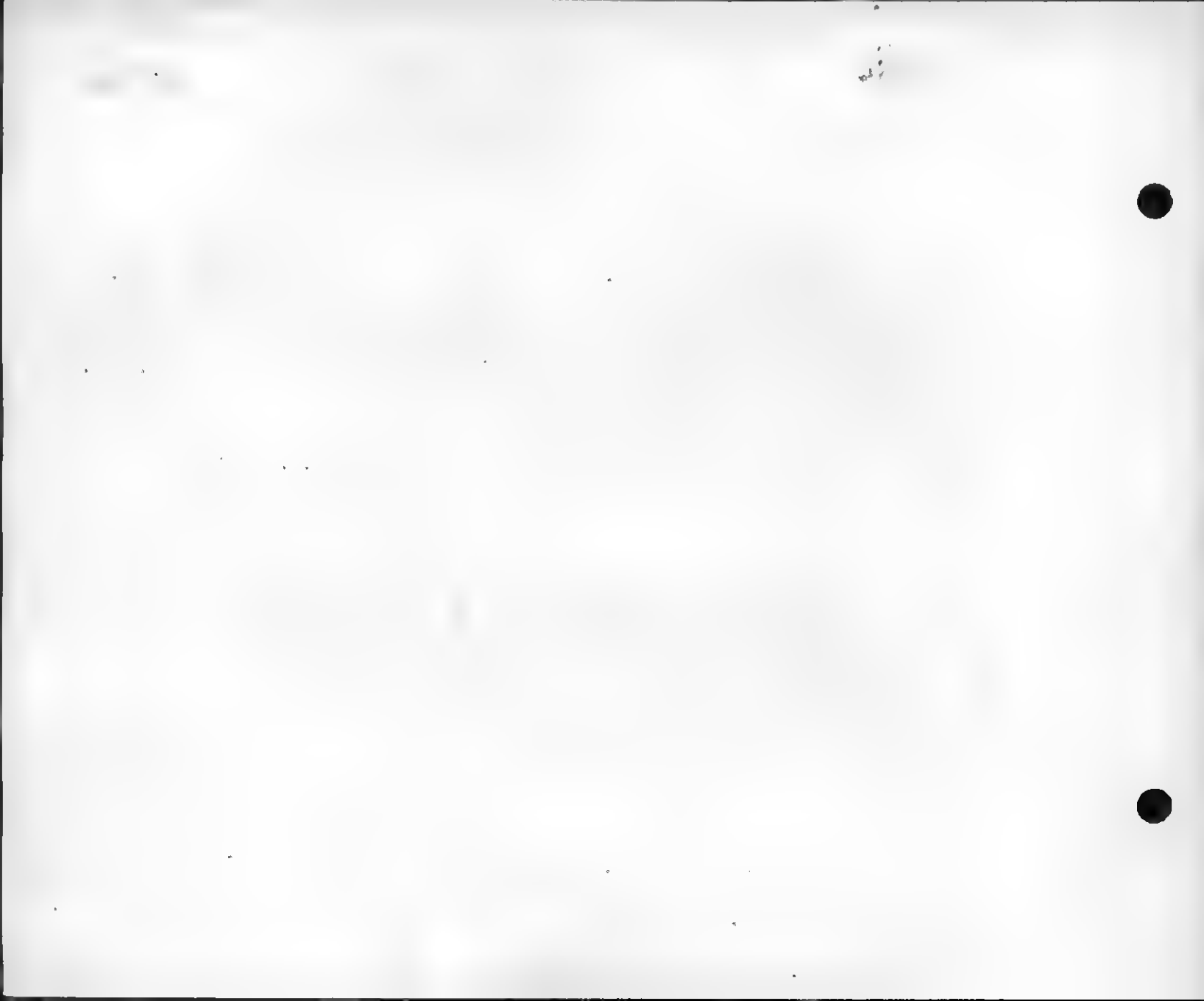
06084

06073

1 PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if inst. tut. on Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) FROSTBURG		c. LENGTH OF STAY IN 1b 3 WEEKS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MINERS HOSPITAL		e. STREET ADDRESS 24 DEPOT ROAD	
3. NAME OF DECEASED (Type or print) First EDNA Middle E. Last WOLFORD		4. DATE OF DEATH Month MAY Day 20 Year 19 67	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUGUST 30, 1890
9. AGE (In years last birthday) yrs. 76		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (County & State, or foreign country) BARTON, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM EDWARD PHILLIPS		14. MOTHER'S MAIDEN NAME NORA ROSS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO 214-07-1633B	
17. INFORMANT MR. ODIS WOLFORD		24 DEPOT ROAD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral occlusion secondary DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerotic Cardiovascular disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 day - years -	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from April , 19 66 to May 20 , 19 66 that (I) (we) last saw the deceased alive on May 20 , 19 67 , and that death occurred at 11 M, from causes and on the date stated above.			
22a. SIGNATURE John B. Davis, M.D.		22b. DATE SIGNED 5/22/67	
22c. PHYSICIAN'S NAME (Type) JOHN B. DAVIS, M.D.		22d. ADDRESS 2 BROADWAY, FROSTBURG, MARYLAND	
23a. BURIAL, CREMATION, or other disposal (Specify) BURIAL	23b. DATE THEREOF MAY 23, 1967	23c. NAME OF CEMETERY OR CREMATORY FROSTBURG MEM. PARK	23d. LOCATION (City or Town) (County) (State) FROSTBURG, MARYLAND
24. FUNERAL DIRECTOR MARILOU M. SOWERS, HAFFER-SOWERS FUNERAL HOME		25. REC'D BY REGISTRAR MAY 25 1967	
26. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06085

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06074

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE PENNSYLVANIA b. COUNTY SOMERSET	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - FROSTBURG		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - SALISBURY	
c. LENGTH OF STAY IN 1b SEVERAL HOURS		75.3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) HOFFMAN ROAD		d. STREET ADDRESS ROUTE #1, BOX 74	
3. NAME OF DECEASED (Type or print) First Judy Middle Lee Last Ziegler		4. DATE OF DEATH Month MAY Day 28 Year 19 67	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 17, 1947
9. AGE (In years lost birthday) 20 yrs.		10. IF UNDER 1 YEAR Months 28 Days 19 Hours 67 Min.	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME KARL H. ZIEGLER		14. MOTHER'S MAIDEN NAME MARY MARGARET LEWIS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 167-40-9585	
17. INFORMANT KARL H. ZIEGLER-RD#1, BOX 74, SALISBURY, PA.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CRUSHED SKULL DUE TO (b) (INFLICTED BY ASSAILANT) DUE TO (c) (INFLICTED BY ASSAILANT)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ASSAILANT STRUCK REPEATED BLOWS WITH ROCKS			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ASSAILANT STRUCK REPEATED BLOWS WITH ROCKS	
20c. TIME OF INJURY Month, Day, Year Hour 11 a.m. MAY 28 19 67 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hoffman Road Near Eckhart Allegany, Md.		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Benedict Skitarelic</i> EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		22. DATE SIGNED MAY 29, 1967 CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF MAY 31, 1967	
23c. NAME OF CEMETERY OR CREMATORY HILLCREST BURIAL PARK		23d. LOCATION (City or Town) (County) (State) NEAR CUMBERLAND, ALLEGANY, MD.	
24. FUNERAL DIRECTOR <i>John J. Hafer, Jr.</i> JOHN J. HAFFER, JR., -230 BALTO. AVE., CUMBERLAND, MD.		25a. REC'D BY REGISTRAR JUN 5 1967	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06086

06075

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			c. LENGTH OF STAY IN 1b 37 DAYS			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL				d. STREET ADDRESS 413 PALASKI STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MYRTLE Middle E. Last ZIMMERMAN				4. DATE OF DEATH Month MAY Day 14 Year 1967			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-14-1900		9. AGE (In years last birthday) 67 yrs.	10. IF UNDER 1 YEAR Months 6 Days 7	11. IF UNDER 24 HRS. Hours 7 Min. 14
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WIFE.			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME HENRY LITTLE				14. MOTHER'S MAIDEN NAME ROSE RICE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 212-24-1274B		17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Heart Failure & Pulmonary Embolism DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) Generalized Atherosclerosis DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary infection; Acute Sclerotic embolism							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1959 , to 5-14 , 19 67 , that (I) (we) last saw the deceased alive on 5-14 , 19 67 , and that death occurred at 2:05 A.M. , from causes and on the date stated above.							
22a. SIGNATURE William P. James				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 5/15/67	
22c. PHYSICIAN'S NAME (Type) WM. P. JAMES				22d. ADDRESS 441 NO. CENTRE ST. CUMBERLAND, MD			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/16/67		23c. NAME OF CEMETERY OR CREMATORY Zion Memorial Park		23d. LOCATION (City or Town) (County) (State) Cumberland Allegany Maryland	
24. FUNERAL DIRECTOR H. Lee Silcox Cumberland Maryland 21502				25a. REC'D BY REGISTRAR MAY 17 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08037

08037

08037

08037

08037

08037

08037

08037

08037

08037

08037

08037

08037

08037

08037

08037

08037

08037

08037

08037

08037

08037

08037

08037

08037

08037

08037

08037

08037

08037

08037